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ABSTRACT

The state plan outlines Ohio's programs and services for people with developmental disabilities (DD). The definition and impact of DD are noted in section 1, and this is followed in sections 2 and 3 by descriptions of the State Planning Council on DD and the State Administering Agency. Section 4 examines the state context, noting the issues and concerns of DD in Ohio and the scope of services administered by the five responsible state agencies, namely, the Ohio Departments of Education, Health, Mental Health, and Public Welfare, and the Ohio Rehabilitation Services Commission. Priority service areas are outlined, and papers and reports are presented on prevention, comprehensive early intervention, respite services, residential services, and manpower training. Section 5 gives the state's goals, objectives, and funding projections for 1984-1986, with emphasis on prevention, early identification/intervention, alternative community living arrangements, manpower training, and special initiatives. Contained in two concluding sections are the state's list of assurances, guidelines for Ohio's operational definition of DD, a map of Ohio's DD planning areas, a review of federally assisted state programs, and the state's employee protection plan for displaced DD workers. (CL)

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OHIO'S STATE PLAN
FOR
DEVELOPMENTAL DISABILITIES

BEST COPY AVAILABLE

1984 - 1986

Ohio Developmental Disabilities Planning Council
and
Ohio Department of Mental Retardation and
Developmental Disabilities

STATE OF OHIO
OFFICE OF THE GOVERNOR
COLUMBUS 43215

RICHARD F. CELESTE
GOVERNOR

September 12, 1983

Robert J. Vogt
Regional Program Director
Region V Office
Administration on Developmental
  Disabilities
300 South Wacker Drive
Chicago, IL 60606

Dear Mr. Vogt:

The State of Ohio is pleased to submit the 1984-1986 State Plan for Developmental Disabilities prepared jointly by the Ohio Developmental Disabilities State Planning Council and the Ohio Department of Mental Retardation and Developmental Disabilities. This document represents the efforts of hundreds of professionals, consumers and citizens who have been involved in planning for Ohio through the initiatives of the Council.

The priorities reflected in the plan are congruent with the priorities of the Administration. Emphasis is placed upon prevention of developmental disabilities and the availability of early intervention services which represent cost savings in both human and economic terms. Development of resources within our communities to enable individuals with developmental disabilities to live in the least restrictive, most productive environment possible supports Ohio's continuing commitment to depopulating institutions and improving the quality of life for its citizens.

The Council continues to provide leadership in promoting cooperative efforts toward a service system which is responsive to the needs of persons with developmental disabilities across public and private sectors at the state and local levels among professionals and consumers. This plan represents an important outcome in this process.

Sincerely,

Richard F. Celeste

RICHARD F. CELESTE
Governor

cc: Minnie Fells Johnson, Ph.D.
    Director, Department of MR & DD

DEVELOPMENTAL DISABILITIES
THREE YEAR STATE PLAN
1984-86

STATE OF
OHIO

Submitted by:

The Ohio Developmental Disabilities
State Planning Council

This State Plan is a joint endeavor of the Ohio Developmental Disabilities State Planning Council and the Administering Agency for Developmental Disabilities, the Ohio Department of Mental Retardation and Developmental Disabilities

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Submitted: 9/13/83

Office of Human Development
Washington, D.C. 20201

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Developmental Disabilities Office
Department of Health and Human Services
Chicago, Illinois 60606

TRANSMITTAL NUMBER
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☐ Annual Revision of State Plan is Attached

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DATE RECEIVED IN REGIONAL OFFICE
REGION

PLAN APPROVED - ONE COPY ATTACHED
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Office of Human Development
Washington, D.C. 20201

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Office of Human Development State Plan Programs

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ACKNOWLEDGEMENTS

The Ohio Developmental Disabilities State Planning Council has designed a planning process which involves consumers, professionals and interested citizens throughout Ohio. A network of committees, task forces, coalitions, service providers, professional organizations and consumer advocacy groups are involved in the development of the State Plan for Developmental Disabilities and the implementation of initiatives which are outlined in the plan. Agencies receiving DD subgrants provide valuable planning information to the Council. In an effort to acknowledge the work of these many individuals, following are the names of organizations which have contributed to the DD Program in Ohio:

Akron University, Department of Counseling and Special Education
American Association of University Affiliated Facilities
Ardmore, Inc.
Ashtabula County Residential Services Corporation
Association for the Developmentally Disabled
Athens County Children's Services Board
Blanchard Valley School
Blick Clinic for Developmentally Disabled, Inc.
Bowling Green State University
Brookhill Residential Services, Inc.
Buckeye Community Services
Central Ohio Chapter, March of Dimes
Central Ohio SERRC
Children's Defense Fund
Children's Diagnostic Center, Inc.
Children's Hospital - Columbus
Cincinnati Center for Developmental Disorders
Citizens' Advisory Boards
Clermont County Association for Retarded Citizens
Cleveland Clinic
Clinton County Board of Mental Retardation & Developmental Disabilities
Cuyahoga County Association for Retarded Citizens
Cuyahoga SERRC
Dayton Area Citizens Committee
Easter Seal Society of Greater Cleveland
Echoing Hills Village, Inc.
Epilepsy Association of Central Ohio
Epilepsy Center of Northwestern Ohio, Inc.
Epilepsy Services Action Council
Fairfield County Board of Mental Retardation & Developmental Disabilities
Family Services Agency of Springfield and Clark County
Flat Rock Children's Center
Frank Porter Graham Child Development Center, The University of
  North Carolina at Chapel Hill
Franklin County Board of Mental Retardation & Developmental Disabilities
Franklin County Children's Services Board
Franklin County Halfway House
Greater Cleveland Hospital Association
HELP for Retarded Children, Inc.
Hamilton County Board of Mental Retardation & Developmental Disabilities
Hamilton County Council for Retarded Citizens
Hancock County Board of Mental Retardation & Developmental Disabilities
Hartville Homes

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Health Education Alliance
Henry County Board of Mental Retardation & Developmental Disabilities
Holmes County Board of Mental Retardation & Developmental Disabilities
Hopewell SERRC
Institute for Human Services
Jefferson County Board of Mental Retardation & Developmental Disabilities
Licking County Council for Retarded Citizens
Lincoln Way SERRC
Marc Gold and Associates
Marion County Board of Mental Retardation & Developmental Disabilities
Mental Retardation/Developmental Disabilities Legislative Coalition
Mercer County Residential Homes, Inc.
Miami Children's Center
Miami Valley SERRC
Mid-Eastern SERRC
Mid-Ohio Board of Independent Living
Mid-Ohio Regional Planning Commission
Montgomery County Board of Mental Retardation & Developmental Disabilities
National Committee on Child Abuse and Neglect
Nisonger Center, The Ohio State University
North Central Ohio SERRC
North East Ohio SERRC
Northeastern Ohio Consortium in Geriatric Medicine and Gerontology
Northern Ohio SERRC
Northwest Ohio SERRC
ODDPC Alternative Community Living Arrangements Committee
ODDPC Child Development Committee
ODDPC Deinstitutionalization Task Force
ODDPC Early Intervention Task Force
ODDPC Interagency Committee
ODDPC Manpower Training Task Force
Office of the Franklin County Commissioners
Ohio Association for Retarded Citizens
Ohio Civil Service Employees' Association
Ohio Coalition for the Education of Handicapped Children
Ohio Coalition of Citizens with Developmental Disabilities
Ohio Commission on Aging
Ohio Consortium
Ohio Department of Education
Ohio Department of Health
Ohio Department of Mental Health
Ohio Department of Mental Retardation & Developmental Disabilities
Ohio Department of Public Welfare
Ohio Department of Rehabilitation and Correction
Ohio Developmental Disabilities Alliance for Service Eligibility
Ohio Head Start
Ohio Hospital Association
Ohio Legal Rights Service
Ohio Long Term Care Council

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Ohio Private Residential Association
Ohio Rehabilitation Services Commission
Ohio Society for Autistic Citizens
Ohio Spina Bifida Coalition
Ohio State Medical Association
Ohio Superintendents of County Boards of Mental Retardation
& Developmental Disabilities
Ohio Tuberous Sclerosis Association
Ohio University Center for Human Development
Ohio University Child Development Center
Ohio University, Institute for the College of Health & Human Services
Ottawa Residential Services
Pilasco-Ross SERRC
Professional Association for Retardation
Project Synergy
Public Images Board of Directors, Inc.
Regional Adaptive Equipment Center
Rehabilitation Service of North Central Ohio
Renaissance Foundation
Residential, Inc.
Richland New Hope Center
Seneca County Board of Mental Retardation & Developmental Disabilities
Sentinel Services
Siffrin Residential Association for Developmental Disabilities, Stark County
Sinclair Community College
Southeastern Ohio SERRC
Southwest Community Health Centers, Inc.
Still Water Health Center
Summit County Board of Mental Retardation & Developmental Disabilities
The Kids on the Block, Inc.
The Media Group
The Ohio State University, Department of Public Administration
The Ohio State University Research Foundation
The Ohio State University School of Social Work
Tourette Syndrome Association of Ohio
Tri-County Community Action Agency
Tri-County Easter Seal
United Cerebral Palsy and Services for the Handicapped, Inc.
United Cerebral Palsy Association of Ohio
United Cerebral Palsy of Columbus and Franklin County
United Cerebral Palsy of Cuyahoga County
United Cerebral Palsy of Lancaster and Fairfield County
United Cerebral Palsy of Metropolitan Dayton
West Haven Foundation for the Retarded

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SECTION 1
DEVELOPMENTAL DISABILITIES: Definition and Impact

What are Developmental Disabilities ?
How Many People have Developmental Disabilities?
What is the "Developmental Disabilities Basic Grant Program ?"

SECTION 1: DEVELOPMENTAL DISABILITIES: Definition and Impact

1.1 What are Developmental Disabilities?

Developmental Disabilities are severe, chronic mental and/or physical impairments which occur at an early age, are likely to continue indefinitely, and have a pervasive effect on an individuals' functional abilities and need for services.

In Public Law 95-602, the Developmental Disabilities Assistance and Bill of Rights Act, Congress stated its findings as follows:

(1) there are more than two million persons with developmental disabilities in the united states;

(2) individuals with disabilities occurring during their developmental period are more vulnerable and less able to reach an independent level of existence than other handicapped individuals who generally have had a normal developmental period on which to draw during the rehabilitation process;

(3) persons with developmental disabilities often require specialized lifelong services to be provided by many agencies in a coordinated manner in order to meet the persons' needs;

(4) general service agencies and agencies providing specialized services to disabled persons tend to overlook or exclude persons with developmental disabilities in their planning and delivery of services; and

(5) it is in the national interest to strengthen or eliminate the need for institutional care, to meet the needs of persons with developmental disabilities. (Section 101 (a))

On July 10, 1981, the Ohio Developmental Disabilities State Planning Council formally adopted the following mission:

> *Based upon the belief that everyone has the potential for positive growth and all persons with developmental disabilities have the right to live in the community and to participate in normal life activities; and that it is possible, through close relationships with legislators and other key figures, to alter value systems and have a positive impact upon the service network; and that comprehensive integration of services can come about as delivery systems are impowered to cooperate, share similar philosophies, promote continuity and reflect effective economizing of resources; the major functions of the Ohio Developmental Disabilities State Planning Council are to continue to find ways to work on prevention to reduce the incidence of developmental disabilities; to achieve interdepartmental coordination in serving all developmentally disabled persons through modification of budget practices, laws and regulations, removal of artificial barriers, adequate funding and administrative sanction to local agencies; to promote understanding and acceptance of the developmentally disabled through an effective public awareness program; to create a better network of services for the developmentally disabled by the elmination of service gaps, the provision of training and the expansion of direct, support and coordination services; to explore new approaches to problems and new issues through planning based upon an improved data base and a commitment to sound implementation; and to strengthen advocacy efforts on behalf of all persons with developmental disabilities, particularly low incidence disabilities, and improve communication mechanisms to influence the service delivery systems.*

1.1.1 The Federal Definition of "Developmental Disability"

Public Law 95-602 as amended, the Developmental Disabilities Assistance and Bill of Rights Act, defines a developmental disability as:

"a severe, chronic disability of a person which -

(a) is attributable to a mental or physical impairment or combination of mental and physical impairments;

(b) is manifested before the person attains age twenty-two;

(c) is likely to continue indefinitely;

(d) results in substantial functional limitations in three or more of the following areas of major life activity:

-self care
-receptive and expressive language
-learning
-mobility

-self-direction
-capacity for independent living, and
-economic self-sufficiency; and

(e) reflects the person's need for a combination and sequence of special interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated." (Section 102(7)).

1.1.2 Ohio's Application of the Federal Definition

Council needs an operational definition in order to identify a target group that can be described for purposes of state-wide planning, program evaluation and systems advocacy. A broad definition in this case is helpful because it can form a basis for shared action and a greater opportunity for success than groups could achieve independently. Dr. Elinor Gollay in Operational Definition of Developmental Disabilities (1981) provides clarification and explication of the federal definition which are useful for planning, evaluation and advocacy. Excerpts from this report were presented in Ohio's FFY 1981-1983 State Plan for Developmental Disabilities and the Council continues to reference the report as a guide.

On another level, however, it is necessary to apply the federal definition in determining an individual's eligibility for service whenever the service is funded under Part C. of P.L. 95-602. The Gollay report contains several charts and a screening checklist which can serve as guidelines for this purpose. Service providers are advised to reference "Relationships among Life Activity Limitations," "Explanations of Areas of Major Life Activity," and the "Key Screening Questions Checklist," in identifying an individual as having a developmental disability as defined by federal law. The charts and checklist appear in Section 7 of this Plan.

1.2 How Many People have Developmental Disabilities?

Findings from the Ohio Developmental Disabilities Prevalence and Needs Survey (1978), funded with DD Program monies, indicate that between 151,875 and 206,116 people in Ohio are experiencing severe functional limitations due to the presence of a developmental disability. These figures are based upon an estimated prevalence rate from this Ohio survey of .014 to .019 and population projections for 1985 published by the Ohio Data Users Center in the Ohio Department of Development. It is important to note that (a) individuals identified as developmentally disabled in this survey are self-defined, that is, the respondent classified and/or described a particular individual as being developmentally disabled and (b) a preliminary screening process used in the survey emphasized a definition of disability based upon functional limitations.

The estimated number of persons with developmental disabilities in Ohio is presented by planning areas used by the Department of Mental Retardation and Developmental Disabilities in Table 1 below.

Table 1

Estimated Number of Persons with Developmental Disabilities in Ohio for 1985 by Planning Region

Planning Area	Total Population	Estimated DD Population
1 - Southwest	2,674,186	37,439 - 50,810
2 - Northwest	1,422,662	19,917 - 27,031
3 - Central	1,683,811	23,573 - 31,992
4 - Cleveland	1,963,810	27,493 - 37,312
5 - Northeast	2,010,951	28,153 - 38,208
6 - Southeast	1,092,793	15,299 - 20,763
State Total	10,848,213	151,874 - 206,116

NOTE: Planning Areas are those of the Ohio Department of MR & DD, as illustrated in Section 7.

Prevalence estimates for three specific disabilities were identified through the Ohio Prevalence and Needs Survey as presented in Table 2.

Table 2

Estimated Prevalence Rates and Population Counts in Ohio for Mental Retardation, Epilepsy and Cerebral Palsy

Disability	Prevalence Rate	Estimated Population
Mental Retardation	.008 - .01	86,785 - 108,482
Epilepsy	.005 - .007	54,241 - 75,937
Cerebral Palsy	.0006 - .0014	6,509 - 15,187

Sources: Ohio Prevalence and Needs Survey
Ohio Data Users Center

Again, it is important to note that these prevalence rates reflect persons who are experiencing severe functional limitations as a result of the presence of the disability.

The Ohio DD Council is currently supporting further exploration of prevalence in two areas. As part of a DD grant entitled "Exploring and Expanding Early Intervention Services," Southwest Community Health Centers, Inc., Columbus, Ohio, is conducting a study (1) to determine the proportion of children aged 0 through 4 in Ohio who have a handicapping condition or who are suspected of being "at risk" for developing a handicapping condition and (2) to explore the experiences and perceptions that parents of these children have with the developmental disabilities service system. A second DD grant entitled "Improving Service Options for Persons with Autism and Developmental Disabilities with Related Severe Behavior Problems" is being expanded to gather together data on the prevalance rates and needs of persons with developmental disabilities which are not Mental Retardation. This beginning effort will continue in fiscal year 1984 through activity 84-32 described in Table 5-1 of this Plan.

1.3 What is the "Developmental Disabilities Basic State Grant Program"?

The Developmental Disabilities Basic State Grant Program is a federally-assisted State program designed to assure "...that persons with developmental disabilities receive the care, treatment, and other services necessary to enable them to achieve their maximum potential through a system which coordinates, monitors, plans and evaluates those services..." (Section 101(b)(1))

The specific purposes of the Basic Grant Program, as outlined in Section 101 (b) (2) of Public Law 95-602, are as follows:

"(A) to assist in the provision of comprehensive services to persons with developmental disabilities, with priority to those persons whose needs cannot be covered or otherwise met under the Education for All Handicapped Children Act, the Rehabilitation Act of 1973, or other health, education, or welfare programs;

(B) to assist States in appropriate planning activities; and

(C) to make grants to States and public and private, non-profit agencies to establish model programs, to demonstrate innovative habilitation techniques, and to train professional and paraprofessional personnel with respect to providing services to persons with developmental disabilities..."

The program works closely with the State Protection and Advocacy Agency "...to ensure the protection of the legal and human rights of persons with developmental disabilities." (Section 101(b)(1)).

The Ohio Developmental Disabilities Planning Council has consistently maintained efforts for coordination and information sharing linkages with the University Affiliated Facilities (UAF's) and University Affiliated Programs (UAP's) in the State. Representatives from these Programs participate regularly on Council Committees, Task Forces and Ad Hoc Subcommittees. Acknowledging the valuable contribution these Programs have to offer for the development of effective service delivery, the Council has provided resources to enable the various programs in Ohio the opportunity for coordinated training across the state. Joint efforts are currently being implemented in the area of continuing education for Child Care Professionals.

SECTION 2

THE STATE PLANNING COUNCIL ON DEVELOPMENTAL DISABILITIES

What is the Council on Developmental Disabilities ?
Who are the Council Members ?
Who are the Council Staff ?

SECTION 2: THE STATE PLANNING COUNCIL ON DEVELOPMENTAL DISABILITIES

2.1 What is the Council on Developmental Disabilities?

The Ohio Council on Developmental Disabilities is a planning body composed of 22 members including persons with developmental disabilities; immediate relatives or guardians of persons with developmental disabilities; and representatives of the principal State agencies, higher education training facilities, local agencies, and non-governmental agencies and groups concerned with services to persons with developmental disabilities. At least 50% of the Council membership must consist of persons with developmental disabilities or parents or guardians of such persons. Of that 50%, one-third must be persons with developmental disabilities and another one-third must be immediate relatives or guardians of persons with mentally impairing developmental disabilities. At least one individual must be an immediate relative or guardian of an institutionalized person with a developmental disability.

Members are appointed by the Governor for two year terms. To assure rotation in membership, no member shall succeed himself more than once, and appointments are staggered to provide for maximum continuity. Each member representing a state agency is excluded from the rotation rule and shall serve as a member of Council as long as he has the status in state government qualifying him for appointment as a member.

In accordance with Public Law 95-602 and Executive Order, Council has several mandated responsibilities:

- to develop the State Plan for Developmental Disabilities jointly with the state administering agency;
- monitor, review and evaluate the implementation of the state plan annually;
- review and comment on all state plans in Ohio which relate to programs affecting persons with developmental disabilities;
- submit reports to the Secretary of the U. S. Department of Health and Human Services, through the Governor, on its activities as periodically required.

The State Plan for Developmental Disabilities, which is developed jointly by the Ohio DD Council and the Ohio Department of MR and DD must:

- at least once every three years, provide for the examination of the provision, and the need for the provision, in the state of the four areas of priority services; which are (1) Case Management, (2) Child Development, (3) Alternative Community Living Arrangements and (4) Non-Vocational Social Development Services;

- provide for the development, review and revision of a comprehensive statewide plan to better address unmet needs in the state in one or two of the priority areas of service;

- specify objectives to be achieved and list programs and resources to be used to meet the objectives;

- describe, at least once every three years, the extent and scope of services provided to persons with developmental disabilities under the state plans and how DD funds will be used to complement and augment services for persons with developmental disabilities which are eligible for Federal assistance under other state programs;

- annually assess and describe the extent and scope of priority services to be provided under the plan;

- establish a method for periodic evaluation of the plan's effectiveness in meeting its objectives.

2.2 Who are the Council Members?

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Betty Weatherly
633 Bell Street
Akron, Ohio 44307

2.3 Who are the Council Staff?

Office Address and Telephone:

Ohio Developmental Disabilities Planning Council
State Office Tower, Room 1020
30 East Broad Street
Columbus, Ohio 43215
(614) 466-5205

Council Staff:

Denis W. Stoddard, Ph.D. Executive Director	Judith Scheiderer Planner
Mark Ostler Administrative Assistant	Anne James Management Analyst
Gwen Crable Administrative Assistant	Mary Smithson Management Analyst
Virginia West Secretary	Marti Harrington Management Analyst
Inez Choice Typist	

Staff Responsibilities:

Executive Director

Represents the Ohio Developmental Disabilities Planning Council to all state and local agencies, the Governor's Office, the Legislature, consumer and advocacy groups and service providers. Supervises Council staff and oversees Council committees, task forces and work groups to design and evaluate the DD Program for the state. Assists the Director of Department of Mental Retardation/Developmental Disabilities in defining the goals and objectives for the developmentally disabled for the state.

Administrative Assistant

Acts as programmatic assistant to the Executive Director and serves as special projects coordinator. Acts as liaison between Executive Director and staff. Staffs the Executive Committee of Council and weekly staff meetings. Responds to requests for information about the DD Council and DD service network.

Administrative Assistant

Develops and modifies fiscal procedures and prepares financial reports, provides technical advice to aid the Executive Director in decision making. Acts for Executive Director in personnel matters. Staffs the Nominating Committee, serves as liaison between the Committee and the Governor's Office, assists the Committee in recruiting candidates for Council membership. Responds to requests for information about the DD Council and the DD service network.

Secretary

Acts as office secretary, produces typed copy of correspondence and reports of highly technical nature; independently responds to correspondence on behalf of the Executive Director; composes correspondence on behalf of Executive Director. Takes minutes and proceedings of Council meetings. Sets up and plans DD Council meeting arrangements as well as for Committees and Task Forces; makes Conference Call arrangements; notifies participants of meetings; arranges conferences and speaking engagements for the Executive Director, DD Council members, and Council staff. Supervises typing and clerical tasks of Typist 2. Presently involved in new filing/retrieval system for office.

Typist

Types routine correspondence, reports, tables, charts from rough drafts of transcribing machine. Xeroxes typed and printed materials. Requisitions supplies and sees that supplies are kept up to date. Answers incoming calls.

Planner

Coordinates the development of the State Plan for Developmental Disabilities. Supervises Management Analysts. Staffs the Interagency Committee of Council. Assists with committee and task force work, grantee evaluation and administrative tasks.

Management Analyst

Evaluates the effectiveness of programs supported with DD funds. Designs and implements plan for impact evaluation of the DD State Plan. Provides consultation to DD funded project personnel regarding the assurance of systemic impact. Initiates liaison activities with selected service network organizations and participates in coordination of the overall operation of Council.

Management Analyst

Staffs the Child Development Committee and Eorly Intervention Task Force. In these areas, conducts assessments of statewide programs serving the developmentally disabled to determine the scope and extent of services available. Identifies major gaps and problems existing in the service system for the developmentally disabled population. Solicits and designs strategies to resolve these problems and determines the feasibility of services. Writes issue papers and assists in the development of goals and objectives for the Ohio State Plan for Developmental Disabilities.

Management Analyst

Staffs the Alternative Community Living Arrangements Committee and the Human Resource Development Committee (formerly the Manpower Training Task Force) of Council. In these areas, conducts assessments of statewide programs serving the developmentally disabled to determine the scope and extent of services available. Identifies major gaps and problems existing in the service system for the developmentally disabled population. Solicits and designs strategies to resolve these problems and determines the feasibility of services. Writes issue papers and assists in the development of goals and objectives for the Ohio State Plan for Developmental Disabilities.

SECTION 3

THE ADMINISTERING AGENCY FOR THE DEVELOPMENTAL DISABILITIES PROGRAM

What is the Designated State Administering Agency ?
Who is the Administering Agency Staff ?

SECTION 3: THE ADMINISTERING AGENCY FOR THE DEVELOPMENTAL DISABILITIES PROGRAM

3.1 What is the Designated State Administering Agency?

In Ohio, the State Administering Agency for the Developmental Disabilities Program is the Department of Mental Retardation and Developmental Disabilities (DMR/DD), located at 30 East Broad Street, 11th Floor, Columbus, Ohio 43215. This designation is authorized by the Governor's Executive Order No. 18-25. Minnie F. Johnson, Ph.D., is Director of this agency, and the appointed representative to the DD Council from DMR/DD.

In fulfilling its responsibilities as the designated State Agency to administer P.L. 95-602 funds, the Ohio Department of Mental Retardation and Developmental Disabilities has designated a Developmental Disabilities Program Unit within the Division of Program Services, Office of Planning and Development.

The Developmental Disabilities Program Unit has the responsibility for the following:

- Administration of Ohio's P.L. 95-602 funds and implementation of the State Plan.
- Development and implementation of policies and procedures for the fiscal administration and program evaluation of all P.L. 95-602 funded activities; i.e., competitive grants, non-competitive negotiations, administration, evaluation and planning activities, ensuring compliance with P.L. 95-602; Code of Federal Regulations - Title 45, Part 74; and all applicable State Regulations.
- Implementation of the grants process including public notice of funds, application review, grant issuance, and orientation to new grantees.
- Communicating to the Ohio Developmental Disabilities Planning Council and to all other interested parties, project awards, project activities, status and outcomes of projects.
- Provide the Department of Health and Human Services with all required financial reports.
- Consult with the DMR/DD, Division of Administrative Services, Office of Fiscal Services, in establishing fiscal control and processing of Federal and State funds applicable to the DD Program.

3.2 Who is the Administering Agency Staff?

In order to perform its responsibilities in administering P.L. 95-602 funds, the Developmental Disabilities Program Unit has a staff consisting of: Sandra Mulholland, Administrator; James L. Wilder, Grant Coordinator; Daphne Miller, Secretary.

The Developmental Disabilities Program Unit Staff are located at
30 East Broad Street, Room 1115, Columbus, Ohio 43215.

The Administrator is responsible for the overall administration of the DD Program. This includes setting policies and procedures for the implementation of the State Plan; the development of sub-grant cycle and procedures; fiscal accountability to the Department of Health and Human Services; collection of data and preparation of reports regarding Developmental Disabilities funded projects; serves as liaison between state agency, federal agency, sub-grantees, and the general public for the DD Program.

The Grant Coordinator is responsible for coordinating the fiscal and program activities of the DD Program; supervises and monitors the sub-grantee process for fiscal and program accountability; provides the administrator with program status reports and fiscal data; provides technical assistance to sub-grantees; performs on-site visits to project locations to review sub-grantee activities.

The Secretary is responsible for performing the standard secretarial functions, as well as assisting the Administrator and Grant Coordinator. This includes managing the correspondence, telephone, office schedule, files and other routine procedures.

SECTION 4
THE STATE CONTEXT

What is the Environment in which the Developmental Disabilities Program Operates in Ohio ?

What are the State's Major Concerns During the Three-Year Plan Period ?

Ohio Developmental Disabilities Planning Council Public Hearings Summary Report

Child Development Prevention Chart

Early Intervention Task Force Concept Papers Analyzing Components of a Comprehensive Early Intervention Program

Respite Services as a Component of Comprehensive Family Support: A Position Paper

Residential Services in Ohio: The Need to Shift from a Facility-Based to a Home-Centered Service System

Manpower Training Task Force Implementation Plan Task Group Report

SECTION 4: THE STATE CONTEXT

4.1 What is the Environment in which the Developmental Disabilities Program Operates in Ohio?

The statewide environmental context in which the Developmental Disabilities Program is operating in Ohio is one that reflects several major factors both in economical and political terms. Among these factors and changes are the following:

1. The election of Governor Richard F. Celeste, a Democrat, replacing a Republican Governor who had been in office for 16 of the last 20 years.

2. The shift in the State Legislature to a Democratically controlled House and Senate.

3. Replacement of essentially all key administrative personnel in all major branches of government including Dr. Minnie Fells Johnson as the new Director of the Ohio Department of Mental Retardation/Developmental Disabilities (ODMR/DD).

4. Elimination of the Regional Office concept in ODMR/DD.

5. The scheduled closing of Orient Developmental Center by December 31, 1983, and one additional Developmental Center by July 1, 1985.

6. The state just beginning to come out of a severe economic recession.

7. A significant state budget deficit to be made up by July 1, 1983.

8. A substantial increase in state income taxes.

9. Due to economic and related difficulties the drawing together of advocacy organizations, service providers and others involved in working with serving individuals with developmental disabilities.

The above-mentioned environmental factors/changes will definitely impact decision making and what will be accomplished over the next three year plan period in terms of improving the quality of life of people with developmental disabilities.

In this same vein, there are several major long range issues/concerns which Ohio Developmental Disabilities Planning Council (ODDPC) has identified which influence the quality of life realized by individuals with developmental disabilities. Three of these are special initiatives of the ODDPC and they relate to (1) awareness and acceptance of individuals with developmental disabilities in the community in general through support of a statewide public awareness campaign, (2) pursuing systems advocacy issues through support and participation in an MR/DD Legislative Coalition and (3) assisting individuals with developmental disabilities to access and receive appropriate services. This third initiative deals with individuals who are not currently receiving appropriate or any needed services due to current state eligibility criteria, severity of handicap, or other complicating factors. This effort is being done through support and participation in the Ohio Developmental Disabilities Alliance for Service Eligibility (ODDASE) and other groups and organizations representing individuals with developmental disabilities that for various reasons, related to problems in public service delivery systems, are not able to obtain appropriate services in the State of Ohio.

4.1.1 Issues and Concerns which Influence Services for People with Developmental Disabilities

One of the long range issues being addressed by the Ohio Developmental Disabilities Planning Council is prevention of developmental disabilities. In the past three years, the Council has played a key role in the expansion of genetic screening services and development of public awareness of the availability of those services. The Child Development Committee and Council are committed to the continued expansion of prevention programs and public and professional awareness activities.

The state's budget deficit and high level of unemployment are two factors which have influenced the Committee's decision-making. Unemployment has been cited as a reason for recent increases in morbidity and mortality rates in numerous Ohio cities. Many families have lost their medical insurance as a result of unemployment. In quite a few Ohio cities and towns, doctors are being asked to treat a certain number of these families gratis. High unemployment rates and the resultant problems within families are also considered significant when analyzing causes of child abuse, which can cause developmental disabilities, particularly in infants and very young children.

Governor Richard Celeste has recently proposed a one million dollar budget increase for prenatal care for Fiscal Year 1984. He also submitted a budget request to the legislature for state funds to begin a state supported child health prevention program to serve the children of unemployed and working families.

Much remains to be accomplished, however, particularly in terms of outreach and public awareness. The Council, in realizing this, has targeted low income, minority and rural populations, and health professionals, in its awareness goals. The Council has also developed a wide range of objectives addressing biological and environmental causes of disabilities and promoting increased knowledge of the methods whereby disabilities can be prevented.

Two other vitally important long range issues being addressed by the DD Council are the need for early identification of all children suspected of being handicapped or at risk of becoming handicapped and the provision of comprehensive early intervention services for those children immediately after they are located and evaluated.

In 1982, the Child Development Committee established an Early Intervention Task Force and charged it with the following mission:

> ...to promote the availability of early intervention services for children 0-4 years in Ohio who are in need of these services.

The existence of the Task Force is a very positive influence per se on the development of a comprehensive, coordinated system of early intervention services in the State of Ohio. The Task Force is an interagency body, with representatives from the Departments of Health, Education, Welfare, Mental Retardation/Developmental Disabilities, as well as Head Start, Nisonger Center and the Cincinnati Center for Developmental Disorders, a pediatrician, and representatives from DD Council Projects. The Task Force has established objectives to develop a model early intervention system for the state and to draft legislation to mandate services for children ages birth through four.

The Task Force believes that conditions are right in Ohio for legislation to be passed within five years. One reason for that belief is the establishment of the MR/DD Legislative Coalition, which can play a key role in informing consumers and public officials about the value and cost-effectiveness of early intervention. The leadership of a strong, dedicated chairperson of the Task Force is another critical factor. Finally, the fact that early intervention is clearly cost-effective and, in the state climate of fiscal restraint, preventing children from needing costlier services at a later time is very practical economically, as well as being highly beneficial to the child, his family, and society.

The Council has attempted to respond from a philosophically and economically sound basis for its development of goals, objectives and activities within the priority service area of Alternative Community Living Arrangements. Presently, the state is engaged in an intensive effort to reduce the population of developmental centers, categorical resources are limited or decreasing while at the same time, new initiatives are being launched and advocacy groups are increasingly more sophisticated in articulating what the needs are and in what manner they should be met. In addition, the state is undergoing an administration reorganization, is in an economic recession and has recently experienced a substantial income tax increase. These factors have contributed significantly to Council decisions on the allocation of resources--decisions which have focused on deinstitutionalization, the need to shift from a facility-based to a home-centered service system and accessing generic services through coordinated interagency efforts.

These same factors have influenced decision making in the area of human resource development. The Council's Manpower Training Task Force, a state level, interagency group, has emphasized state and local interagency coordination, effective use of the expertise of manpower development specialists in helping organizations efficiently make a difference in meeting the needs and improving the quality of life for the people being served and the avoidance of duplication of effort in a number of areas.

4.1.2 The Scope of Services for Persons with Developmental Disabilities

In Ohio, five state agencies are responsible for administering the nine federally assisted programs referenced in P.L. 95-602 Section 133(b)(2)(B)(i) as programs of service essential to individuals with developmental disabilities. They are as follows:

Ohio Department of Education (ODE)
...education for the handicapped

Ohio Department of Health (ODH)
...maternal and child health
...crippled children's services
...comprehensive health

Ohio Department of Mental Health (ODMH)
...mental health

Ohio Department of Public Welfare (ODPW)
...public assistance
...medical assistance
...social services

Ohio Rehabilitation Services Commission (ORSC)
...vocational rehabilitation

The Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD) is the agency in Ohio charged with promoting comprehensive statewide programs and services for persons with mental retardation and their families. In addition, we in Ohio are fortunate to have two University Affiliated Facilities: The Nisonger Center at the Ohio State University and the University Affiliated Cincinnati Center for Developmental Disorders.

The mandated functions, service descriptions and eligibility requirements for the nine federally assisted programs, as well as programs offered by ODMR/DD and our UAF's, are discussed in the following paragraphs. A Matrix showing discreet services available by agency appears in Section 7 of this plan.

Education for the Handicapped

State Planning Agency: Ohio Department of Education, Division of Special Education
Public Law Number: U.S. P.L. 94-142
Public Law Title: To amend the Education of the Handicapped Act to provide educational assistance to all handicapped children, and for other purposes.

Mandated Functions:

P.L. 94-142 provides that a free appropriate public education will be available for all handicapped children between the ages of three and eighteen within the State not later than September 1, 1978, and for all handicapped children between three and twenty-one within the State not later than September 1, 1980 (unless ages three to five or eighteen to twenty-one, inclusive, are inconsistent with State law). In addition, P.L. 94-142 requires that all children residing in the State who are handicapped, regardless of the severity of their handicap, who are in need of special educational and related services, are identified, located, and evaluated; and that a practical method is developed and implemented to determine which children are currently receiving needed special educational and related services and which are not.

Description of Services:

Special education means specially designed instruction, at no cost to parents or guardians, to meet the unique needs of a handicapped child, including classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions (P.L. 94-142, section 4 (16)). Services related to special education are transportation, and such developmental, corrective, and other support services as may be required to assist a handicapped child to benefit from special education. Related services include early identification and assessment of handicapping conditions in children, speech pathology and audiology, psychological services, occupational and physical therapy, physical education, recreation, counseling services, and medical services (except that such medical services shall be for diagnostic and evaluation purposes only). (O.R.C. 3323.01) Related services also include school health services, social work services in schools, and parent counseling and training (45 CFR 12(a)(13)0).

Eligibility:

A handicapped child is a person under twenty-two years of age who is mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, orthopedically impaired, multiply impaired, or otherwise health impaired, or who has specific learning disabilities (O.R.C. 3323.01). In Ohio, all handicapped children age 5 through 21 are to be provided with an appropriate public education.

Title V Maternal and Child Health Services Block Grant

State Planning Agency: Ohio Department of Health, Division of Maternal and Child Health
Public Law Number: U.S. P.L. 74-271 as amended
Public Law Title: The Social Security Act provides for the general welfare by establishing a system of Federal old-age benefits, and by enabling the several states to make more adequate provision for aged persons, blind persons, dependent and crippled children, maternal and child welfare, public health, and the administration of their unemployment compensation laws; to establish a Social Security Board; to raise revenue; and for other purposes.

Mandated Functions:

Funds under Title V-Maternal and Child Health Services Block Grant are to be used to:

1. assure mothers and children (especially low income or those with limited availability of health services) access to quality health services;

2. reduce infant mortality and incidence of preventable diseases and handicapping conditions among children, reduce need for inpatient and long-term care, increase number of children appropriately immunized and the number receiving health assessments and follow-up diagnostic and treatment services and otherwise to to promote the health of mothers and children;

3. provide rehabilitation services for blind and disabled children under 16 years old who receive Supplemental Security Income benefits; and

4. provide for the location, diagnosis, treatment and after-care of crippled children.

Description of Services:

Funds may be used for the provision of health services and related activities (including planning, administration, education and evaluation) consistent with the state agency's description of intended expenditures and statement of assurances. The Division of Maternal and Child Health provides the following services through the:

1. Bureau of Maternal and Child Health - awards grants funds for local agencies to provide prenatal care, high-risk perinatal services, infant and child health services, family planning and adolescent health services, communicative and sensory disorders care, genetics services, lead based paint poison prevention and services for Sudden Infant Death Syndrome; and the

2. Bureau of Crippled Children's Services - (a) authorizes services to diagnose children suspected of having a medically eligible handicapping condition and (b) authorizes services to treat financially and medically eligible handicapped children. Services to assure the early location, and of handicapped children and the prevention of handicaps are provided.

Eligibility:

Mothers and children who are of low-income or who have limited availability of health services are eligible to receive maternal and child health and/or crippled children's services where they are provided.

Health Planning and Resources Development

State Planning Agency: Ohio Department of Health
Public Law Number: U.S. P.L. 93-641, as amended by U.S. P.L. 96-79
Public Law Title: To amend the Public Health Service Act to assure the development of a national health policy and of effective state and area health planning and resources development programs, and for other purposes.

Short Title: National Health Planning and Resources Development Act of 1974

Mandated Functions:

P.L. 93-641 authorizes the designation of a State Health Planning and Development Agency (SHPDA), a Statewide Health Coordinating Council (SHCC), and a network of Health Systems Agencies (HSA's) for the purpose of implementing a national health planning policy, through areawide and statewide planning for health services, manpower, and facilities.

Description of Services:

Health planning organizations are to develop plans for health services that address the following national priorities:

1. The provision of primary care services for medically underserved populations, especially those which are located in rural or economically depressed areas.
2. The development of multi-institutional systems for coordination or consolidation of institutional health services (including obstetric, pediatric, emergency medical, intensive and coronary care, and radiation therapy services).
3. The development of medical group practices (especially those whose services are appropriately coordinated or integrated with institutional health services), health maintenance organizations, and other organized systems for the provision of health care.
4. The training and increased utilization of physician assistants, especially nurse clinicians.
5. The development of multi-institutional arrangements for the sharing of support services necessary to all health service institutions.
6. The promotion of activities to achieve needed improvements in the quality of health services, including needs identified by the review activities of Professional Standards Review Organizations under part B of Title XI of the Social Security Act.
7. The development of health service institutions of the capacity to provide various levels of care (including intensive care, acute general care, and extended care) on a geographically integrated basis.

8. The promotion of activities for the prevention of disease, including studies of nutritional and environmental factors affecting health and the provision of preventive health care services.

9. The adoption of uniform cost accounting, simplified reimbursement, and utilization reporting systems and improved management procedures for health service institutions and the development and use of cost saving technology.

10. The development of effective methods of educating the general public concerning proper personal (including preventive) health care and methods for effective use of available health services.

11. The promotion of an effective energy conservation and fuel efficiency program for health service institutions to reduce the rate of growth of demand for energy.

12. The identification and discontinuance of duplicative or unneeded services and facilities.

13. The adoption of policies which will (a) contain the rapidly rising costs of health care delivery, (b) ensure more appropriate use of health care services, and (c) promote greater efficiency in the health care delivery system.

14. The elimination of inappropriate placement in institutions of persons with mental health problems and the improvement of the quality of care provided those with mental health problems for whom institutional care is appropriate.

15. Assurance of access to community mental health centers and other mental health care providers for needed mental health services to emphasize the provision of outpatient as a preferable alternative to inpatient mental health services.

16. The promotion of those health services which are provided in a manner cognizant of the emotional and psychological components of the prevention and treatment of illness and maintenance of health.

17. The strengthening of competitive forces in the health services industry wherever competition and consumer choice can constructively serve, in accordance with subsection (b), to advance the purposes of quality assurance, cost effectiveness, and access.

Eligibility:

Eligibility for planning grants authorized by P.L. 93-641, as amended, is restricted to agencies designated as SHPDA or an HSA. HSA's, however, may make payments under contract with other entities for assistance in the performance of functions. Ohio is designated as a single agency state under section 1536 and operates without HSA's.

Public Assistance: Supplemental Security Income (SSI)

Administering Agency: Social Security Administration, U. S. Department of Health and Human Services
Public Law Number: U.S. P.L. 92-603
Public Law Title: To amend the Social Security Act, and for other purposes.

Mandated Functions:

The purpose of the Supplemental Security Income (SSI) program is "to assure a minimum level of income for people age 65 or over; or who are blind or disabled and who do not have sufficient income and resources to maintain a standard of living at the established Federal minimum income level." (20 CFR 416.110)

Description of Services:

SSI provides the recipient with a monthly income payment. The amount of payment is determined according to the recipient's living arrangement and additional sources of support. Maximum SSI benefits for an eligible individual living alone is $284.30 (7-82) per month as of 7/82.

Eligibility:

An individual is considered disabled under this program if he/she is unable to engage in any substantially gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted, or can be expected to last, for a continuous period of not less than twelve months (or in the case of a child under eighteen, if he suffers from any medically determinable physical or mental impairment of comparable severity). A physical or mental impairment is an impairment which results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. For purposes of determining eligibility for and treatment of benefits for any individual who is a child under age twenty-one, such individual's income and resources shall be deemed to include any income and resources of a parent of such individual (or the spouse of such a parent) who is living in the same household as such individual, except as determined inequitable by the Secretary of HHS.

Medical Assistance: Medicaid

State Planning Agency: Ohio Department of Public Welfare
Public Law Number: U.S. P.L. 89-97, as amended
Public Law Title: To provide health care for certain low income persons who cannot pay for medical services.

Mandated Funcions:

Title XIX (Medicaid) of the Social Security Act authorized federal grants to states for medical assistance to low income persons who are 65 or over, blind, disabled, or members of families with dependent children. Payments for services are made directly by the state to the individuals or entities that furnish the services. The program is jointly financed by the Federal and State governments and administered by the states, within broad Federal rules; each state decides eligible groups, types, and range of services, payment levels for services, and administrative and operating procedures.

Description of Services:

Medicaid reimbursement can be obtained in the following service categories: hospital services; physicans' services; dental care; vision care; pediatric care; chiropractic care; physical therapy; mechanotherapy; psychology; private duty nursing; pharmacy; medical supplies; lab and x-ray services; home health care; ambulatory health care; early, periodic screening, diagnosis and treatment services (E.P.S.D.T.); planned parenthood; long-term care facilities; and ambulance and ambulette service. Medicaid reimbursements made to institutional settings may include room and board, laundry, equipment and supplies, personal care services, nursing care, special dietary service, and other specialized and supportive rehabilitation services prescribed by an attending physician.

Eligibility:

- Members of families receiving Aid to Dependent Children (ADC).
- People 65 or older whose income and financial resources are below levels established in Ohio's statewide plan.
- The blind adult or child whose income and financial resources are below levels established in Ohio's statewide plan.
- The disabled adult or child whose income and financial resources are below levels established in Ohio's statewide plan.
- People receiving day care benefits.
- Residents of nursing homes whose income does not meet the cost of care.

Social Services: Title XX

State Planning Agency: Ohio Department of Public Welfare
Public Law Number: P.L. 97-35
Public Law Title: Title XX Block Grants to States for Social Services
purpose is to provide social services that will enable residents of Ohio to restore, maintain, or improve their capabilities for self-support, self-cure, independent living, and for strengthening family life.

Mandated Functions:

Federal legislation has established the following national goals which are stated in broad, general terms. For the purposes of consolidating Federal assistance to states for social services into a single grant, increasing State flexibility as practicable under the conditions in that State.

To furnish services directed at the goals of:

1. achieving or maintaining economic self-support to prevent, reduce or eliminate dependency;

2. achieving or maintaining self-sufficiency, including reduction or prevention of dependency;

3. preventing or remedying neglect, abuse or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating, reuniting families;

4. preventing or reducing inappropriate institutional care by providing for community-based care, or other forms of less intensive care;

5. securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions.

Description of Services:

Twenty-seven categories of services are covered by Title XX reimbursements:

Adoption, Chore, Community Based Care for Adults, Counseling, Day Care for Adults, Day Care-Child Employment and Training, Day Care-Child Protective, Day Care-Child Special Needs; Day Treatment for Children, Developmental Services Children and Youth, Employment and Training, Family Planning, Health Related, Home-Delivered and Congregate Meals, Homemaker/Home Health Aide, Home Management, Information and Referral, Legal, Placement Services for Children, Protective Services for Adults, Protective Services for Children, Residential Treatment for Children, Socialization Developmental Services for Adults, Special Services for Alcohol and Drug Addicts, Special Services for Communicatively Impaired, Transportation.

(From the 1983 Comprehensive Social Services Plan)

Eligibility:

Consumers may be determined eligible for Title XX services on the basis of their income maintenance status (i.e., receipt of ADC or SSI) on the basis of their family income, without regard to eligibility factors, or Group Eligibility determination 60 years of age and over.

Comprehensive Mental Health Services

State Planning Agency: Ohio Department of Mental Health
Public Law Number: U.S. P.L. 97-35, Omnibus Budget Reconciliation Act of 1981
Public Law Title: Amends the Public Health Service Act
Block Grants for Alcohol and Drug Abuse and Mental Health Services

Mandated Functions:

P.L. 94-63 constructed guidelines and authorized assistance for the planning and operation of community mental health centers. P.L. 97-35 extends the commitment to community mental health centers. A community mental health center is an entity through which comprehensive mental health services are provided (1) primarily to individuals residing in a defined geographic area, and (2) within limits of its capacity, to any individual residing or employed in such area, regardless of his ability to pay for such services, his current or past health condition, or any other factor.

Description of Services:

The comprehensive mental health services which shall be provided through community mental health centers shall include (P.L. 97-35, Section 1914 and 1915): (1) the development of more effective alcohol and drug abuse treatment and prevention programs; (2) specialized services, including identification and assessment, for the chronically mentally ill, severely disturbed children and adolescents, and the mentally ill elderly; (3) day treatment or other partial hospitalization services, pre-hospital screening, and consultation and education services.

Eligibility:

Basic eligibility requirements are mentioned under Mandated Functions, above. In addition, the comprehensive mental health service system shall be developed to assure that services shall be available and accessible promptly, as appropriate, and in a manner which preserves human dignity and assures continuity and high quality care.

Vocational Rehabilitation

State Planning Agency: Ohio Rehabilitation Services Commission
Public Law Number: U.S. P.L. 93-112 as amended by U.S. P.L. 95-602
Public Law Title: To replace the Vocational Rehabilitation Act, to extend and revise the authorization of grants to States for Vocational Rehabilitation Services, with special emphasis on services to those with the most severe handicaps. To expand special Federal responsibilities and research and training programs with respect to handicapped individuals, to establish special responsibilities in the Secretary of Health, Education, and Welfare, and for other purposes.

Mandated Functions:

Under P.L. 93-112, Federal grants are authorized (Title I, Part A, Section 100(a)) to assist states to meet the current and future needs of handicapped individuals, so that individuals may prepare for and engage in gainful employment to the extent of their capabilities.

Description of Services:

The scope of the Agency's vocational rehabilitation program should include the following services (45 CFR 1361.1(ee)): (1) Evaluation of rehabilitation potential, including diagnostic and related services, incidental to the determination of eligibility for, and the nature and scope of services to be provided; (2) counseling, guidance, referral; (3) physical and mental restoration services; (4) vocational and other training services, including personal and vocational adjustment, books, tools, and other materials; (5) maintenance; (6) transportation; (7) services to members of the handicapped individual's family when such services are necessary to the adjustment or rehabilitation of the handicapped individual; (8) interpreter services for the deaf; (9) reader services for the blind; (10) telecommunications sensory, and other technological aids and devices; (11) recruitment and training services to provide new employment opportunities; (12) placement in suitable employment; (13) post employment services necessary to assist handicapped individuals to maintain suitable employment; (14) occupational licenses, tools, equipment and initial stocks and supplies; (15) other goods and services which can reasonably be expected to benefit a handicapped individual in terms of his employability.

Eligibility:

Eligibility for vocational rehabilitation services is determined through diagnostic study. In preliminary diagnostic study, to be determined are (1) whether the applicant has a physical or mental disability which constitutes or results in a substantial handicap to employment, and (2) whether vocational rehabilitation services may reasonably be expected to benefit the individual in terms of employability or whether an extended evaluation of rehabilitation potential is necessary to make such a determination (45 CFR 1361.34).

Mental Retardation and Developmental Disabilities Services

Mental Retardation Services: The Ohio Department of Mental Retardation and Developmental Disabilities (DMR/DD) was created on July 1, 1980 by Amended Substitute House Bill 900 (1980). This bill administratively separated the Divisions of Mental Health and Mental Retardation which existed within the Department of Mental Health and Mental Retardation and established two separate departments. DMR/DD operates under the Ohio Revised Code which prescribes its responsibilities.

Mandated Functions:

The mandated functions of the Ohio Department of Mental Retardation and Developmental Disabilities are as follows (according to 5123.02 of the Ohio Revised Code):

"The Department of Mental Retardation and Developmental Disabilities shall:

1. Promote comprehensive statewide programs and services for the mentally retarded and their families wherever they reside in the state. These programs shall include public education, prevention, diagnosis, treatment, training, and care;

2. Provide administrative leadership for statewide service which include residential facilities, evaluation centers, and community classes which are wholly or in part financed by the Department of Mental Retardation and Developmental Disabilities as provided by section 5119.33 of the Revised Code;

3. Develop and maintain, to the extent feasible, data on all services and programs for the mentally retarded provided by governmental and private agencies;

4. Make periodic determinations of the number of retarded persons requiring services in the state;

5. Provide leadership to local authorities in planning and developing community-wide services for the mentally retarded and their families;

6. Promote programs of professional training and research in cooperation with other state departments, agencies, and institutions of higher learning."

Description of Services

The Ohio Department of Mental Retardation and Developmental Disabilities provides services to developmentally disabled people of all ages and provides residential care both in 13 developmental centers and in various communities.

Some of the services are provided by department staff, others are provided through county mental retardation programs which receive reimbursement for their clients through the department. The department also sets standards of operation for the county school programs and sheltered workshops.

The department is also responsible for seeing that clients receive protective and guardianship services. Currently, these services are being provided through contract with a private, non-profit corporation.

The central and area offices have staffs which coordinate services in the institutions and in the communities. Case coordination through the central and area offices is offered for admissions, discharges, residential services, and coordination of services (see Regional Office Rules 5119-13-03(E)(5)).

Other broad areas of services include individual and comprehensive habilitation plans for each client, awarding construction grants to help communities open residential homes and workshops following all state, local and federal regulations, to protect the health and safety of clients in state facilities, and family resources including respite care to help maintain people in the community.

Through the county programs, developmentally disabled people receive special education, job training, evaluation and employment, psychological services, and services to infants through adults. Although not a mandated service some counties provide case management.

Eligibility:

All developmentally disabled people in Ohio are eligible for at least some kinds of services from the department; however, the definition of developmental disabilities contained in the Ohio Revised Code is not the same as the federal definition.

The Ohio Revised Code defines "developmental disability" as:

> "...having a disability that originates before age 18, has continued or can be expected to continue indefinitely, and constitutes a substantial handicap to the person's ability to function normally in society, and is attributable to one of the following:
>
> 1. Mental Retardation, cerebral palsy, the epilepsies or autism
>
> 2. Any other condition found to be closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons or requires treatment and services similar to those required for such persons
>
> 3. Dyslexia resulting from a disability described in this division.
>
> As used in this division, 'substantial handicap means a handicap that results in significant deficits in two or more areas of adaptive behavior. Individuals are developmentally disabled, under this definition, when deficits in two or more areas of adaptive behavior are commensurate with those of an individual diagnosed as moderately, severely, or profoundly mentally retarded.'"

However, the federal definition resulting from the 1978 amendments now reads:

> "...a developmental disability: (1) is severe and chronic; (2) is attributable to a mental or physical impairment; (3) is manifested before age 22; (4) is expected to continue indefinitely; (5) results in substantial functional limitation in three of seven specified areas of major life activities; and (6) reflects the need for lifelong and individually planned services."

The Nisonger Center

Overview:

The Nisonger Center was established as a University Affiliated Facility at the Ohio State University as a vehicle for the training of professionals in a variety of disciplines to serve persons with developmental disabilities. A significant part of the training program involves participation by students in a variety of different clinics which offer comprehensive interdisciplinary diagnosis, assessment, and planning for clients who are suspected to have developmental disabilities. Clients with developmental delays/dysfunctions may also enroll in ongoing intervention programs depending upon their needs and the availability of community services. In addition, recent efforts have been directed toward greater specificity of training goals and outcomes, the development of strategies which are responsive to the inter-relationships that exist in training, service, research dissemination and community outreach/linkage.

Goals:

The essential mission of the Nisonger Center is reflected in the following goals:

1. To provide students from various disciplines with the opportunity to obtain knowledge and skills in the field of mental retardation and developmental disabilities through an interdisciplinary problem solving approach.

2. To offer exemplary services to the handicapped population as a vehicle for training.

3. To foster the spirit of scientific inquiry and conduct clinical and applied research in high priority areas in the field.

4. To develop, demonstrate, and disseminate program models related to prevention, intervention, and habilitation that effectively resolve the problems of mental retardation and developmental disabilities.

5. To collaborate with other Ohio colleges and universities in the assessment of training needs and the provision of training programs for community personnel.

6. To promote the coordination of community service delivery systems, particularly the health delivery system, and to utilize those systems for university student training experiences.

7. To encourage and cooperate with efforts to maximize the effectiveness of community prevention, intervention, and habilitation programs for handicapped individuals.

8. To interact with state and local agencies and organizations toward the creation and implementation of legislation and standards to improve the delivery of prevention, intervention and habilitation service programs to individuals who are mentally retarded or developmentally disabled.

9. To train future leaders in teaching, service and research in the area of mental retardation and developmental disabilities.

10. To develop a greater university investment in community activities related to the handicapped.

Scope of Services:

The mission of Nisonger Center is depicted in multi-facted activities which seek to provide a variety of interesting training experiences for students while at the same time meet the service needs of the clients.

The Interdisciplinary Training Program is responsible for the organization, administration, coordination and development of all clinical services and student training activities of the Center. Fulfillment of these various responsibilities ensure that interdisciplinary and disciplinary training and clinical services, as well as clinical research, are coordinated through a central location and are functioning as a cohesive model for students, faculty, staff and the community as a whole. Disciplines represented at the Center include adapted physical education, audiology, child psychiatry, dental hygiene, language, neurology, nursing, nutrition, occupational therapy, pediatrics, pedodontics, physical therapy, psychology, social work and special education.

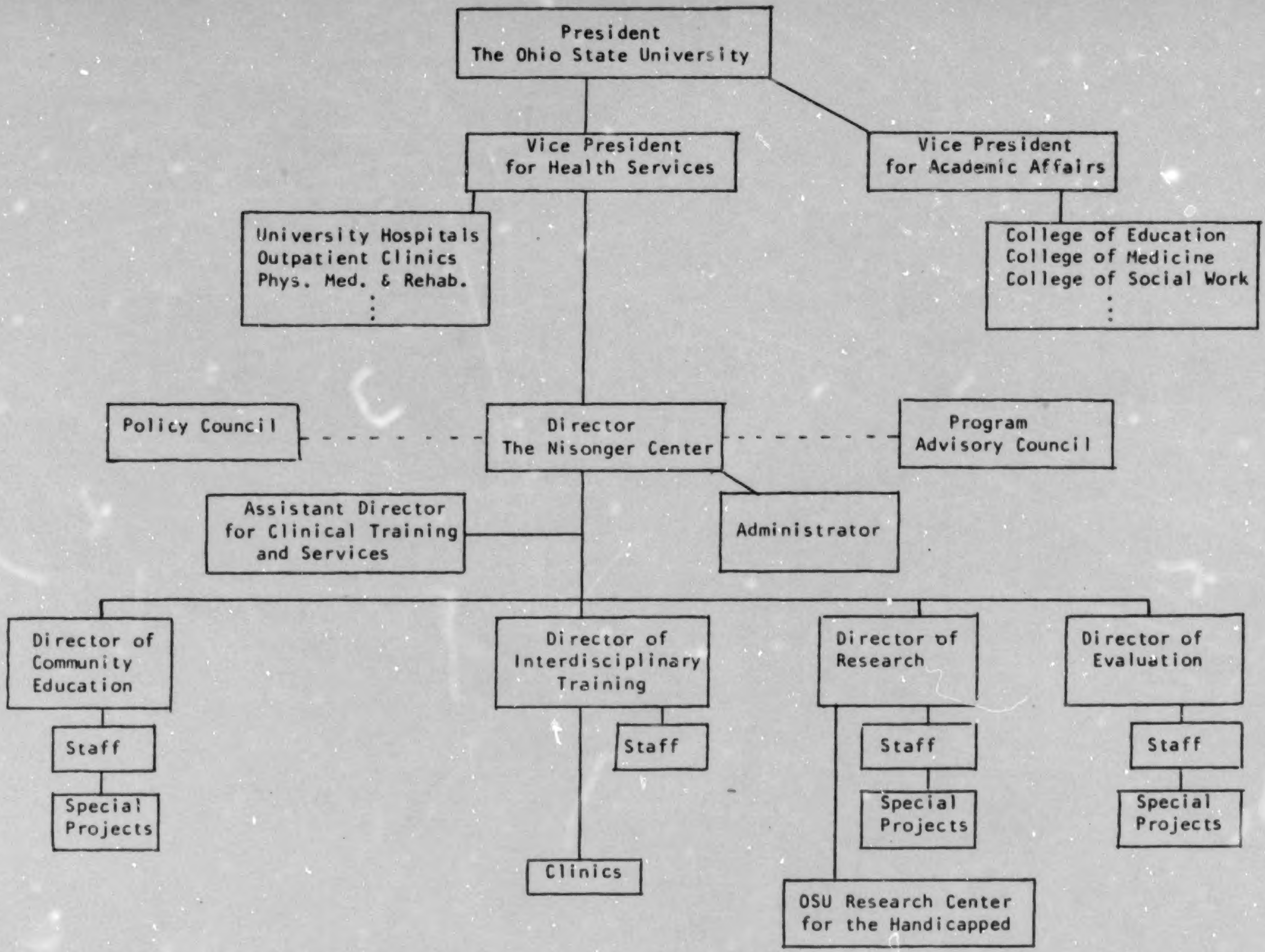
The Evaluation Program was established primarily to provide information to assist decision making at the Center and to facilitate its overall functioning. A major emphasis has been placed on accurately documenting activities and services and evaluating the impact of various programs. The results of these evaluations provide information on Nisonger Center's compliance with federal mandates, as well as assisting in improving the quality of services for handicapped children and their families.

The Community Education Program functions primarily as the Center's outreach arm, providing the structure necessary for aligning community needs with Center resources and expertise. The community served by the program is a broad and varied one, encompassing administrative and supervisory personnel as well as direct care staff, specialists in the mental retardation/developmental disabilities field and professional non-specialists, parents of handicapped children, university students, and secondary and vocational school students.

The Center has been active in a variety of research, demonstration, and curriculum development projects. These projects, which focus on issues related to mentally retarded and developmentally disabled individuals, are conducted under a variety of formats for one or more of the following purposes:

1. To advance the state of knowledge.
2. To demonstrate exemplary service delivery.
3. To provide training to pre-service and practicing professions.
4. To provide technical assistance to professions and service delivery agencies.
5. To develop materials to be used in working with the handicapped.
6. To develop diagnostic and assessment instruments for working with the handicapped.

Demonstration of exemplary service is a primary mission of the Nisonger Center. Clinical services are available to all clients on an as-needed and availability-of-service basis. The Center accepts for consideration any persons with suspected or confirmed mental retardation or developmental disability. Upon acceptance, a client is seen by a group of professional personnel from the Center in conjunction with family and appropriate community personnel. This group includes many disciplines working together to gain the best possible management plan for the client. Graduate students from these disciplines participate in activities, learning through the experience to conduct competent evaluative planning and management services.


President
The Ohio State University
Vice President
for Health Services
Vice President
for Academic Affairs
University Hospitals
Outpatient Clinics
Phys. Med. & Rehab.
College of Education
College of Medicine
College of Social Work
Policy Council
Director
The Nisonger Center
Program
Advisory Council
Assistant Director
for Clinical Training
and Services
Administrator
Director of
Community
Education
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Interdisciplinary
Training
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Research
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OSU Research Center
for the Handicapped

University Affiliated Cincinnati Center for Developmental Disorders

Overview:

University Affiliated Cincinnati Center for Developmental Disorders (UACCDD) provides programs of professional training, client services, research and demonstration, and community outreach/continuing education related to developmental disabilities (DD). These programs are carried out by an interdisciplinary staff of approximately 50 professionals and over 150 consultants, attempting to serve a tri-state region consisting of approximately 6 counties in southwestern Ohio, 7 counties in northern Kentucky, and 5 counties in eastern Indiana.

Goals:

UACCDD, within the framework of Children's Hospital Medical Center (CHMC) and the University of Cincinnati (UC), working collaboratively with other existing resources, is attempting to establish the Cincinnati region as a model in the field of DD through professional training, interdisciplinary client services, research and demonstration projects, information dissemination, and leadership in interagency coordination of services. The Ideal or Purpose Goals of UACCDD are:

1. to expand the pool of professional personnel through university supervised, comprehensive, coordinated, interdisciplinary programs for the specialized training of those disciplines providing services to individuals with DD

2. to offer, in conjunction with the affiliates of CHMC and other community health, welfare, and educational agencies, the needed continuum of care by providing a complete gamut of outpatient and inpatient interdisciplinary programs appropriate to the habilitation or rehabilitation of individuals with DD from birth through adolescence and to develop mechanisms for their transfer to adult units that can continue their programs

3. to demonstrate and disseminate new techniques of specialized services and/or new approaches for the delivery of services, diagnosis, treatment, education, training or care of individuals with DD; as well as more effective methodology for interdisciplinary professional training, including evaluative research on both service and training

4. to conduct clinical research, applied research, and research in behavioral sciences which will be coordinated with UC and Mental Retardation Research Center/Institute for Developmental Research (MRRC/IDR). UACCDD will eventually be able to complement and supplement the research programs in the biological sciences of the MRRC/IDR by a program of basic research in the behavioral sciences

Scope of Services:

Interdisciplinary Training: UACCDD provides university-based interdisciplinary pre-service/in-service training annually for approximately 6,675 professionals, including about 175 Trainees (active participants in the UAF interdisciplinary program), about 1,000 Non-UAF students (academic course participants taught by UAF faculty), and approximately 5,500 Special Training Program Participants (special programs including workshops, seminars, public information activities, etc.). These individuals, representing all academic levels and about 30 disciplines/specialties/programs from the University of Cincinnati and over 10 other colleges and universities, receive some training experience from UACCDD faculty, staff and consultants representing about 50 academic departments/divisions/programs/professional disciplines. Trainees participate as case managers or members of interdisciplinary teams, consultants; and in outreach activities, research, field visits, services, etc. Almost 75% of 544 trainees with 300+ contact hours between FY 67 and FY 82 have been or were employed in DD related positions, UACCDD, or other university/training positions.

Exemplary Services: UACCDD offers essential direct interdisciplinary comprehensive services, often at a tertiary level of care not available elsewhere in the Cincinnati Tri-State Region, to infants, children, and adolescents from 0-21 years of age with unusually complex handicaps. UACCDD provides through a team of medical/health-related and behavioral/educational professionals, assisted by various consultants and laboratory procedures, a comprehensive interdisciplinary diagnostic evaluation and develops individualized plans for the optimalization of the child's potential. Each year, approximately 500 new evaluations and 250 reevaluations are completed requiring over 16,000 interviews, and with a total of ca. 1,400 cases in process for evaluation. Selective ongoing treatment/management programs are provided annually in over 10,000 visits for over 2,000 individuals in UACCDD or UACCDD-related programs, including Myelomeningocele, Cerebral Palsy, High Risk Infant Follow-up, Diagnostic Therapy Observation Classrooms (e.g. Preschool Observation and "Autistic-like"), Adolescent DD, Dentistry for the Handicapped, Metabolic Disorders Treatment, individual and group counseling and others. In addition, the UACCDD Applied Research Laboratory/Genetic Counseling Regional Center, one of the major centers of the Ohio Department of Health Statewide Regionalized Network of Genetic Services, annually serves about 600 individuals (children and adults) through metabolic and cytogenetic studies, genetic counseling, prenatal diagnosis, and Craniofacial Anomaly Team consultation.

Examples of exemplary service program models which have been replicated include myelomeningocele team program, severe learning disabilities laboratory classroom, classroom for school-aged "autistic-like" children, dental program for the handicapped, metabolic disorders treatment program, etc.

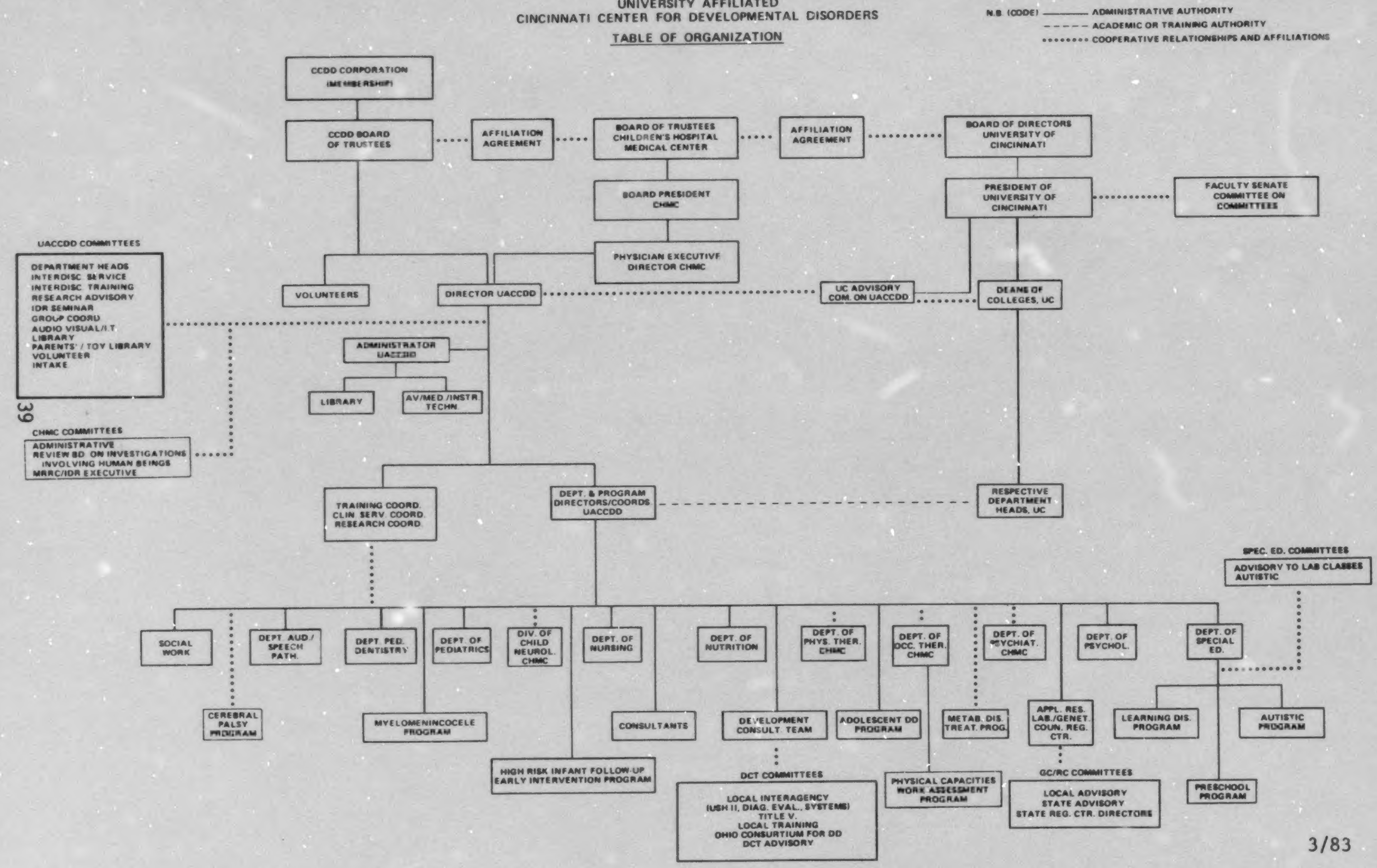
To improve community services for individuals of all ages, including adults with developmental disorders, UACCDD's Development Consultation Team annually provides outreach programs, including in-service training, continuing education planning and consultation, to approximately 1,500 service providers from over 200 community generic, specialized, residential and Title V-related agencies. UACCDD continues to provide to selected agencies one or more consultative services needed to fill significant gaps in their diagnostic evaluations/ongoing services on specific clients, without unduly swelling our own caseload.

Research and Demonstration: Each year, staff and trainees of UACCDD/UACCDD-related programs are involved in more than 70 research, applied research, and demonstration projects, including case studies, behavioral research, new models of service delivery, and community interagency collaboration.

Dissemination of Information: UACCDD disseminates training, service and/or research information to UAF professional staff and trainees, service area providers, researchers and government agencies. Vehicles of dissemination include the activities of the outreach Development Consultation Team, special training and manpower development grants, publications, presentations, conferences, and approximately 70 publications or presentations each year.

To meet the national program goal of the UAF program, including dissemination, UACCDD is involved in joint efforts with other UAFs on a state/regional/national basis in areas of relevant UAF activities: Ohio Consortium for DD for statewide continuing education; Central Conference of University Training Programs in DD (UAF Media Exchange), Region V DD Regional Advisement Technical System (Region V UAFs, state DD planning councils, and P&As), AAUAP (National Meeting, electronic mail system, Data Base, Board, Training Coordinators, Interdisciplinary Council, Disciplines, Outreach), national disciplinary meetings, Birth Defects Information System, and Nisonger Center's national collaborative effort for the development of curriculum in DD for pediatric residents.

UNIVERSITY AFFILIATED
CINCINNATI CENTER FOR DEVELOPMENTAL DISORDERS
TABLE OF ORGANIZATION


N.B. (CODE) ——— ADMINISTRATIVE AUTHORITY
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CCDD CORPORATION (MEMBERSHIP)
CCDD BOARD OF TRUSTEES
AFFILIATION AGREEMENT
BOARD OF TRUSTEES CHILDREN'S HOSPITAL MEDICAL CENTER
AFFILIATION AGREEMENT
BOARD OF DIRECTORS UNIVERSITY OF CINCINNATI
BOARD PRESIDENT CHMC
PRESIDENT OF UNIVERSITY OF CINCINNATI
FACULTY SENATE COMMITTEE ON COMMITTEES
PHYSICIAN EXECUTIVE DIRECTOR CHMC
UACCDD COMMITTEES
DEPARTMENT HEADS
INTERDISC. SERVICE
INTERDISC. TRAINING
RESEARCH ADVISORY
IDR SEMINAR
GROUP COORD
AUDIO VISUAL/I.T.
LIBRARY
PARENTS' / TOY LIBRARY
VOLUNTEER
INTAKE
VOLUNTEERS
DIRECTOR UACCDD
UC ADVISORY COM. ON UACCDD
DEANS OF COLLEGES, UC
ADMINISTRATOR UACCDD
LIBRARY
AV/MED./INSTR. TECHN.
CHMC COMMITTEES
ADMINISTRATIVE
REVIEW BD. ON INVESTIGATIONS INVOLVING HUMAN BEINGS
MRRC/IDR EXECUTIVE
TRAINING COORD.
CLIN. SERV. COORD.
RESEARCH COORD.
DEPT. & PROGRAM DIRECTORS/COORDS. UACCDD
RESPECTIVE DEPARTMENT HEADS, UC
SPEC. ED. COMMITTEES
ADVISORY TO LAB CLASSES AUTISTIC
SOCIAL WORK
DEPT. AUD./SPEECH PATH.
DEPT. PED. DENTISTRY
DEPT. OF PEDIATRICS
DIV. OF CHILD NEUROL. CHMC
DEPT. OF NURSING
DEPT. OF NUTRITION
DEPT. OF PHYS. THER. CHMC
DEPT. OF OCC. THER. CHMC
DEPT. OF PSYCHIAT. CHMC
DEPT. OF PSYCHOL.
DEPT. OF SPECIAL ED.
CEREBRAL PALSY PROGRAM
MYELOMENINCOCELE PROGRAM
HIGH RISK INFANT FOLLOW-UP EARLY INTERVENTION PROGRAM
CONSULTANTS
DEVELOPMENT CONSULT. TEAM
ADOLESCENT DD PROGRAM
METAB. DIS. TREAT. PROG.
APPL. RES. LAB./GENET. COUN. REG. CTR.
LEARNING DIS. PROGRAM
AUTISTIC PROGRAM
DCT COMMITTEES
LOCAL INTERAGENCY
(USH II, DIAG. EVAL., SYSTEMS)
TITLE V.
LOCAL TRAINING
OHIO CONSURTIUM FOR DD
DCT ADVISORY
PHYSICAL CAPACITIES WORK ASSESSMENT PROGRAM
GC/RC COMMITTEES
LOCAL ADVISORY
STATE ADVISORY
STATE REG. CTR. DIRECTORS
PRESCHOOL PROGRAM

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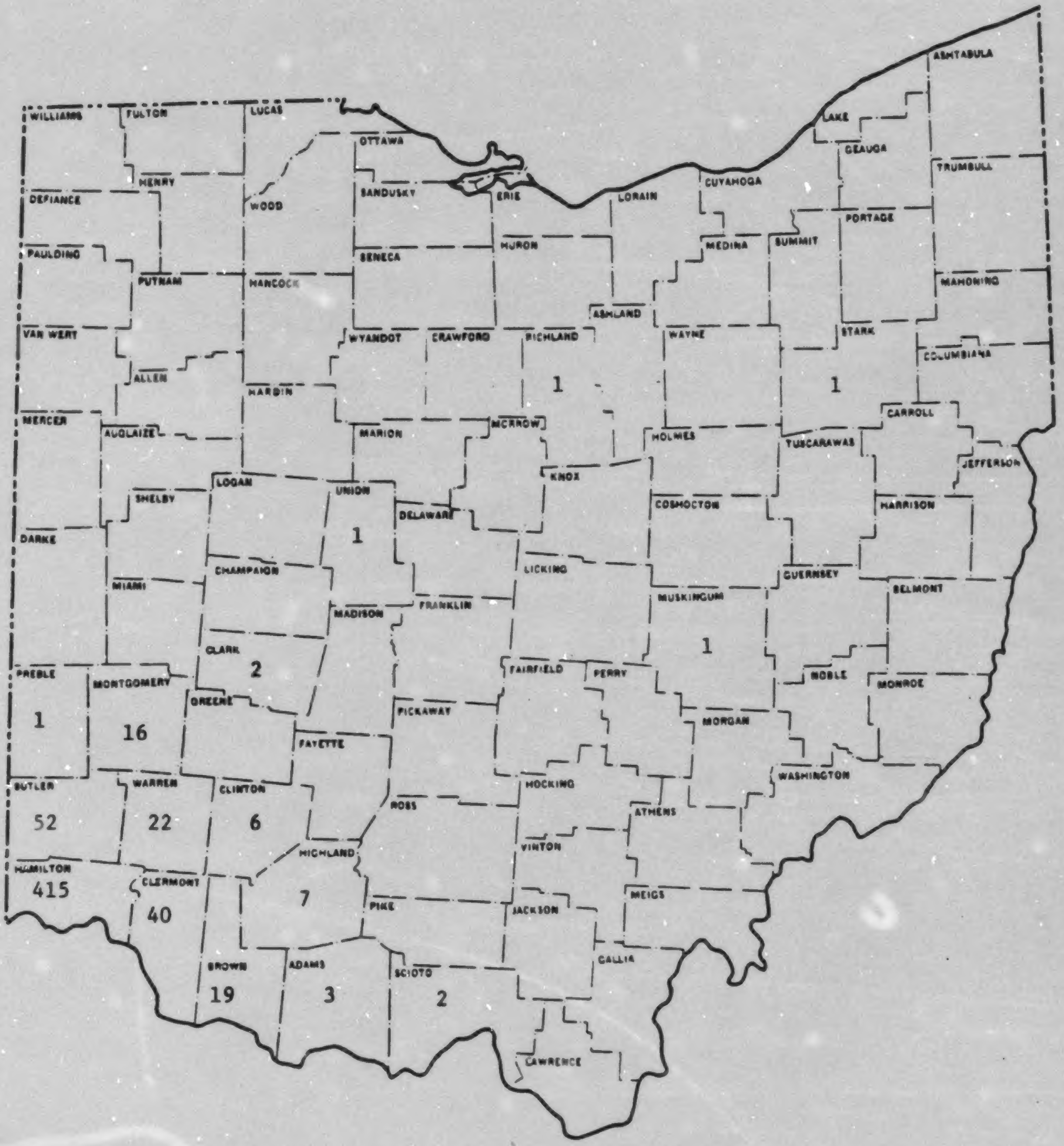
CINCINNATI CENTER FOR DEVELOPMENTAL DISORDERS

1/1/82 - 12/31/82



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4.1.3 Areas of Federal Emphasis

A. Efforts to assist persons with developmental disabilities in urban and rural poverty areas

The Ohio Developmental Disabilities Council is addressing the federal program requirement to undertake efforts to assist persons with developmental disabilities in urban and poverty areas in one of the Child Development objectives. An allocation is being made for two years to the Ohio Department of Health to purchase or develop and distribute public awareness materials on prevention in counties with high morbidity and mortality rates, counties which also have high unemployment rates. The Department of Health is being asked to distribute the materials in sites which will ensure that low-income and minority women have access to them. Proposed distribution sites are to include health care facilities serving the indigent, welfare offices, food stamp centers, laundromats, libraries, grocery stores, churches and Community Action Centers. In addition, the Health Department will acquire or develop public service announcements for television on prevention topics. The announcements are to target low-income and minority women.

B. Efforts to assess the adequacy of professionals and paraprofessionals serving persons with developmental disabilities in the State and the adequacy of State programs and plans supporting training of such professionals and paraprofessionals in maintaining the high quality of services provided to persons with developmental disabilities in the State. (or Assurance 6.14)

The Council continues to support the Manpower Training Task Force which was established in February, 1981. The Task Force is composed of key staff development personnel from other state agencies and individuals from the field of mental retardation and developmental disabilities with a particular expertise in manpower training and staff development. The Task Force has formalized its relationship with the major state agencies through memoranda of understanding. The Task Force has several general areas of responsibility: (1) to act in an advisory role to the Department of Mental Retardation and Developmental Disabilities regarding issues of manpower training and staff development, (2) to act in an advisory role to the Developmental Disabilities Planning Council and its major Committees regarding manpower training and staff development, (3) to serve in an advisory role to the local multi-county training consortia as established under the implementation of the 1984-86 DD State Plan, (4) to initiate the development of materials and training related to the concept of systemic manpower training and (5) to facilitate the interface among major state agencies represented on the Council specific to manpower training issues, needs and programs. The Task Force continues to address the professional assessment mandate through its cooperative linkage with the Ohio Department of Mental Retardation and Developmental Disabilities and the implementation of their statewide Staff Development and Training Plan. As presented in the FFY 1982 DD State Plan, the Council determined that the intent of the professional assessment mandate would be fulfilled through this cooperative effort.

An assessment of needs has been accomplished. The results of the assessment indicate that the need for staff development and training is ongoing, reflects all levels of staff functioning and includes a wide variety of training needs areas. Selected needs-based training has been conducted across the State in response to the assessment.

Further implementation of the plan is contingent upon the current reorganization of the Department of Mental Retardation and Developmental Disabilities and the extent to which resources are allocated to this component of the service delivery system.

C. Efforts to assure participation of individuals generally representative of the State population, with particular attention to the participation of members of minority groups. (or Assurance 6.13)

Council continues efforts to assure the participation of persons representative of the state population, with particular attention to minority groups. The Nominating Committee of Council conducts ongoing recruitment for membership on a statewide basis and evaluates nominees using numerous criteria, including the maintenance of balance on Council whenever possible. The allocation to the Ohio Department of Health described in Section 4.1.3 (A) focuses upon reaching minority women with information about prevention of developmental disabilities. In addition, during 1983 Council conducted a survey of all County Programs for Mental Retardation and Developmental Disabilities to determine the extent to which Native Americans are served by our system.

4.2 What are the State's Major Concerns During the Three-Year Plan Period?

The major identified concerns regarding the prevention of developmental disabilities and early identification and intervention are:

- attempting to obtain permanent funding for University Affiliated Programs (UAPs) and University Affiliated Facilities (UAFs) since they are, of necessity, overly dependent on grants and, thus, the consumers and the general population may lose valuable research, training, diagnostic and service programs
- providing continuing education opportunities for health, welfare, DD, and generic service professionals on the topic of prevention of developmental disabilities
- expanding and improving public awareness and outreach efforts and activities, targeting not only the general public throughout Ohio but also specific groups, including school children and low-income and minority women in counties with high morbidity and mortality rates
- ensuring that professionals in the developmental disabilities field are aware of the link between Child Abuse and disabled children, and that the professionals receive training on Child Abuse
- establishing a model system of comprehensive, coordinated early intervention services for all young children with or at risk of developmental delays/disabilities or other handicapping conditions
- drafting legislation for a strong, non-permissive mandate for the expansion of ongoing identification, location and evaluation of all children suspected of being handicapped and the provision of comprehensive services for all developmentally delayed children ages 0 through 4
- increasing public awareness of the value and cost-effectiveness of early intervention
- conducting additional research on the long range issues, needs and barriers in the area of early identification of children with or at risk of developing handicapping conditions
- securing data on the effectiveness and cost efficiency of early intervention programs through program evaluation

- training parents to successfully access and maintain appropriate comprehensive services for their children

Major concerns in the areas of Alternative Community Living Arrangements and Manpower Training include the following:

- ameliorating the effects on a family which has a child with developmental disabilities through the provision of a comprehensive system of support services that will enable that child to remain in the natural home

- ensuring that deinstitutionalization and the development of community alternatives reflect the philosophy of a home-centered approach to residential and support services and that the assumptions underlying such movements are philosophically sound

- ensuring that the needs of persons with developmental disabilities and related special needs are identified and that the service system is adequate to meet those needs

- assisting training and staff development activities at both local and state levels to be conducted in an effective, systematic and coordinated manner and to contribute to the overall goals of an organization

Three major concerns which cut across all programmatic areas are also addressed in this plan:

- encouraging and enabling consumers and professionals in the field of MR/DD to work cooperatively and effectively in advocating with state and federal legislators on behalf of the population

- establishing a statewide campaign for public awareness about developmental disabilities which will, as an integral part of its functioning, increase the capacity of MR/DD organizations to gain needed community support for appropriate programming

- developing strategies to meet the needs of persons who have developmental disabilities but not mental retardation through research, education and coalition building

These major concerns being addressed by Council over the next three years were identified through the planning process which began with public hearings held during August of 1981 in six locations throughout Ohio. Input to the planning came from citizens who attended these hearings as well as consumers and professionals who participate in committee and task force work for the Council. The Child Development and Alternative Community Living Arrangements Committees examine issues in these priority service areas and develop goals and objectives for recommendation to Council. Beginning in the Spring of 1982, the Child Development Committee established an Early Intervention Task Force so that this area could be researched in greater depth. The Deinstitutionalization Task Force funded in the FFY 1981-83 State Plan for Developmental Disabilities formulated, with assistance from its subcommittees, philosophical guidelines and recommendations for Ohio in issue areas related to deinstitutionalization. This group's work served as the basis from which the Alternative Community Living Arrangements Committee developed recommendations. The Manpower Training Task Force, established in 1981 by the Alternative Community Living Arrangements Committee, now reports directly to the Council on manpower related issues as well as providing consultation to the other standing Committees.

Council continues to support the Ohio Public Images Consortium through the funding of the Public Awareness Campaign. This network of professionals concerned with public information related to developmental disabilities provides planning input as well as technical assistance to Council efforts. Council also participates in and supports the MR/DD Legislative Coalition and the Ohio Developmental Disabilities Alliance for Service Eligibility. The former is a coalition of consumers and professionals which advocates for appropriate programming and funding at the state and federal levels of government. The latter is a group of consumers and professionals who represent persons with developmental disabilities but not mental retardation concerned with access to the service system and eligibility for services.

In addition, Council has less formalized relationships with various advocacy and professional groups around the state, such as the Ohio Association for Retarded Citizens, the Professional Association for Retardation and the Ohio Superintendents of County Boards of Mental Retardation and Developmental Disabilities through which a broad base of information about issues and concerns is maintained.

In the spring of each year, the Executive Committee of Council receives recommended goals, objectives, activities and allocations of DD funds from the Child Development Committee, the Alternative Community Arrangements Committee and the Manpower Training Task Force. These group's priorities are meshed together with the special initiatives of the Executive Committee. This plan is then presented to Council for approval. Thus, the State Plan for Developmental Disabilities is truly a reflection of the thinking of the hundreds of concerned citizens, consumers and professionals from state and local, public and private organizations about directions and priorities for Ohio.

During the past two years, a number of reports have been compiled by committees and task forces of Council as well as Council staff and DD grantees. Following is a list of those which contributed, in part, to planning and decision making related to Council's major concerns. Presented in the remainder of this section are several of these data sources selected for inclusion based upon their close relationship to Council's priorities. These are marked with asterisks.

Public Hearings, September, 1981, "Summary Report,"
Ohio Developmental Disabilities Planning Council*

"Prevention Chart," Child Development Committee*

"Concept Papers Analyzing Program Components of a Comprehensive
Early Intervention Program,"
Early Intervention Task Force*

"Early Intervention Programs in Ohio,"
Southwest Community Health Centers, Inc.

"The Resource Inventory Technique: Assessing the Status of
Early Intervention Services in Ohio,"
Southwest Community Health Centers, Inc.

"The Nominal Group Technique as a Means for Assessing the
Needs of the 0-4 Population in Ohio,"
Southwest Community Health Centers, Inc.

"The Delphi Technique as a Means for Assessing the Needs
of the 0-4 Population in Ohio,"
Southwest Community Health Centers, Inc.

"The Prevalence and Incidence of Developmental Disabilities
and Other Handicapping Conditions,"
Southwest Community Health Centers, Inc.

"The Future of Institutional Services in Ohio: Do We Need to
Plan for Institutional Services?"
Deinstitutionalization Task Force

"Residential Services in Ohio: The Need to Shift from a Facility-Based to a Home-Centered System,"
Deinstitutionalization Task Force*

"Future Directions in Adult Services,"
Deinstitutionalization Task Force

"Promoting Quality Community Living Through Formal Support Services,"
Deinstitutionalization Task Force

"Administrative and Fiscal Directions for a Community Based Service Delivery System,"
Deinstitutionalization Task Force

"Respite Services as a Component of Comprehensive Family Support: A Position Paper,"
Ohio Society for Autistic Citizens*

"Family Support Services: Meeting the Needs of Persons with Severe Behavior Problems,"
Ohio Society for Autistic Citizens

"A Home Centered, Integrated Approach to the Provision of Residential Services for Persons with Severe Behavior Problems," Ohio Society for Autistic Citizens

"Service Needs and Resources Report: Persons with Developmental Disabilities and Related Severe Behavior Problems,"
Ohio Society for Autistic Citizens

"Systemic Manpower Training, Manpower Training Task Force Implementation Plan Task Group Report"*

"The Ohio Tourette Study," Tourette Syndrome Association of Ohio

4.3 What are "Priority Service Areas"?

The Federal Developmental Disabilities Act requires each state to assess the service needs of all developmentally disabled citizens with special emphasis on four service areas identified in the legislation as requiring special consideration. These four areas are listed and defined in paragraph 4.3.1.

The Act further requires each State Developmental Disabilities Program to commit at least 65% of the Federal allotment to "service activities" in one or, at the State's option, two targeted service areas. These targeted areas are referred to as the "State's Priority Service Areas." (The number of "priority service areas" which may be addressed varies dependent on the level of Federal funding. If Federal program funding exceeds $60,000,000 nationally, then States may name a third priority service area.)

If a State elects to name only one "State Priority Service Area", then the State must name one of the four service areas identified by the Federal legislation as requiring special consideration. If the State opts to select two "State Priority Service Areas", the additional service area may be any service area that has been documented as needed to enhance services to citizens with developmental disabilities.

The process and justification for selection of the State's priority service area(s) is provided in paragraph 4.3.2. The current priority service areas are named in paragraph 4.3.3.

4.3.1 The Federal Definitions of "Priority Service Areas" and the Elements of Those Services as Operationalized in Ohio.

A. Case Management: Services which will assist persons with developmental disabilities in gaining access to needed social, medical, educational and other services; includes follow-along services which ensure a continuing relationship, lifelong if necessary, between a provider and a person with developmental disabilities and the person's immediate relatives or guardians; includes coordination services which provide support, access to and coordination of other services, information on programs and services and monitoring of progress. (Section 102(B)(C)(i)(ii))

Elements of Case Management Services in Ohio: Various case coordination approaches by staff assigned case coordination as primary or secondary task in public and private, state and local agencies throughout Ohio.

B. Child Development Services: Services which will assist in the prevention, identification, and alleviation of developmental disabilities in children, and includes early intervention, counseling and training of parents, early identification and diagnosis and evaluation. (Section 102(8)(D)(i)(ii)(iii)(iv))

Elements of Child Development Services in Ohio:

Prevention - services for families, adults and infants at risk for mental retardation and developmental disabilities.

Biological:

- genetic counseling and screening
- rubella immunizations
- prenatal care clinics
- regionalized system of perinatal services for high risk mothers and newborns
- EPSDT
- Crippled Children's Services

Environmental:

- public assistance, food stamps, WIC, and other income maintenance, health and nutrition programs for the lower socio-economic population
- programs to prevent substance abuse
- mental health services
- family planning services
- lead paint screening (statewide program being designed)
- child abuse prevention programs

Early Identification and Intervention

- child find
- perinatal care for high risk infants
- interdisciplinary diagnosis and assessment
- individual program plans
- early intervention programs
- home based programs
- Children's Protective Services
- Crippled Children's Services
- Speech, hearing and vision screening

C. Alternative Community Living Arrangement Services: Services which will assist persons with developmental disabilities in maintaining suitable residential arrangements in the community, including in-house services (such as personal aides and attendants and other domestic assistance and supportive services, family support services, foster care services, group living services, respite care, and staff training, placement, and maintenance services. (Section 102(B)(E))

Elements of Alternative Community Living Arrangements Services in Ohio:

- protective services
- group living services
- placement and maintenance services
- home training services
- respite services
- employment/training
- daily living skills training

D. Non-Vocational Social-Development Services: Services which will assist persons with developmental disabilities in performing daily living and work activities. (Section 102(B)(F))

Elements of Non-Vocational Social-Development Services in Ohio:

- special olympics
- recreation programs
- daily living skills training
- respite services
- day activity centers

4.3.2 The process by which Ohio's Priority Service Areas are Selected.

When planning began four years ago for the last three year State Plan for Developmental Disabilities, the Ohio DD Council selected Alternative Community Living Arrangements (ACLA) and Child Development (CD) as the two priority service areas toward which efforts would be focused. Ohio has been actively moving from institutional settings to small community based living arrangements for persons with developmental disabilities. Thus, ACLA was an obvious choice in order to support the direction already established by the Department of MR and DD. Child Development Services was also a logical choice based upon the fact that Ohio has no comprehensive mandate for services to children from birth through four years. Services do exist, but are not coordinated, are not comprehensive, are not universally available and are, in many cases, permissive. Results of public hearings held in 1978 and deliberations of professionals and consumers involved in Council's planning committees contributed to the selection of ACLA and CD as priority service areas in 1981-1983.

4.3.3 Ohio's Priority Service Areas

Through the process described in paragraph 4.3.2, Ohio has selected the following priority service area(s) for special emphasis during the next three years:

1. Alternative Community Living Arrangements
2. Child Development

While progress has been noted in Ohio over the past several years, ACLA and CD remain the major foci of Council's efforts for 1984-1986. Ohio's deinstitutionalization movement has picked up momentum and the continuing work of Council's Deinstitutionalization Task Force will be available to contribute in this area along with several other grants planned for the next three years. Public awareness and advocacy initiatives begun during the last planning cycle will also continue to contribute to the deinstitutionalization movement in Ohio. Concern among consumers and professionals continues to focus also upon appropriate intervention services for children with developmental disabilities. The prevention and early identification/intervention initiatives presented in this plan reflect experiences and data gathered over the past three years and will benefit Ohio citizens in terms of cost savings as well as improved quality of life.

OHIO DEVELOPMENTAL DISABILITIES PLANNING COUNCIL

PUBLIC HEARINGS
September, 1981

SUMMARY REPORT

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I. Overview

In cooperation with the Ohio Department of Mental Retardation and Developmental Disabilities (ODMR/DD), Public Hearings were held on the Ohio State Plan for Developmental Disabilities, FFY 1981-1983, during September, 1981. Sessions were convened in the afternoon and evening in six locations of Ohio: September 15, 1981, Akron; September 16, 1981, Cleveland; September 17, 1981, Athens; September 22, 1981, Toledo; September 23, 1981, Columbus; and September 24, 1981, Cincinnati. Notices of the Public Hearings were disseminated through mailing lists from the ODMR/DD and the Developmental Disabilities Council, and were published in the legal section of local newspapers.

Consumers and providers of services for persons with developmental disabilities, along with other interested citizens were invited to attend the public hearings and were encouraged to address, within the priority areas, the needs of the developmentally disabled and action to better meet these needs in Ohio. Comments regarding new priorities for FFY 1984 were also encouraged.

A total of 84 individuals attended and/or participated in the hearings with a total of 35 individuals providing oral or written testimony. It is interesting to note that the majority of participants were providers who attended the afternoon session. Through an informal poll, information was obtained from participants that seemed to indicate that notices published in the legal section of local newspapers was not an effective dissemination method.

The remainder of this report summarizes the number of persons who attended and those who provided testimony and the needs, problems and recommendations as articulated through informal comments and formal testimony.

II. Compilation of Persons Attending

Numbers in Attendance:

Representation:	Afternoon	Evening	Total
Consumers	10	7	17
Providers	61	2	63
Interested Citizens	3	1	4
Total:	74	10	84

III. Compilation of Testimony

Number who Testified (oral and written):

Representation:	Afternoon	Evening	Total
Consumers	3	5	8
Providers	24	2	26
Interested Citizens	0	1	1
Total:	27	8	35

IV. Summary of Needs, Gaps, Problems - Informal Comments and Formal Testimony

Information provided through formal testimony and informal comments on the needs, gaps and problems in services for persons with developmental disabilities in Ohio reflect the following areas of concern which are listed in order according to the number of comments received:

- affirmative action, appropriate planning, workshops, vocational training, alternative living arrangements, manpower training, etc., on behalf of persons with low incidence developmental disabilities
- a variety of respite program options in all areas of the state with a permanent funding base
- in-home support mechanisms for families
- day program options for children with developmental disabilities
- early identification/early intervention programs, especially for the 0-2 years of age population
- emphasis on development of community support services especially residential alternatives, recreation options, mental health services, training for all persons with developmental disabilities for independent living, one-to-one citizen advocacy, employment and vocational training for persons with developmental disabilities who are not appropriate for existing workshops, case management
- services which provide continuity of care
- broad-based linkages between workshops and industry
- full range of services for seizure prone persons and their families including counseling, education, employment, transportation, adequate Medicaid care and education for health care professionals and the general public
- coordination of service delivery across agencies, plans between state level planning agencies, services between DD service provider agencies
- professionals not listening to consumers
- accessing Bureau of Crippled Children's Services resources
- designing habilitation plans for very young children
- lack of clarification and compatibility of the definition of developmental disabilities
- multiple licensing requirements
- ratio of travel time to service time in certain geographical areas
- lack of information on role and function of sheltered workshops in relationship to other areas of vocational training
- lack of mandated responsibility for community residential development
- complexity of accessing HUD Sec. 202 monies

V. Summary of Recommendations - Informal Comments and Formal Testimony

A wide variety of recommendations were provided by persons giving formal testimony and by individuals who participated in informal discussion. In some instances recommendations reflect specific action to resolve needs or problems previously identified. Other recommendations were non-specific in that they only indicated that strategies need to be formulated to address certain problem areas. Written and verbal recommendations appear to reflect activities within Council's roles of planning, influencing and coordinating and are summarized within those categories. Planning recommendations include addressing:

- the role and function of sheltered workshops
- service needs of persons with Epilepsy
- vocational and employment needs of adults with developmental disabilities
- mental health needs of persons with developmental disabilities and their families
- service needs of persons with low incidence developmental disabilities
- options for long range funding for respite
- a comprehensive respite service delivery system
- early identification/intervention services, particularily for children from birth to 2 years of age who are developmentally disabled or at risk for developmentally disabled
- support services for persons with developmental disabilities who are living independently
- manpower training in the areas of low incidence developmental disabilities, day care centers
- residential needs for persons with developmental disabilities who are aged or severely handicapped

Influencing and coordinating activities which were recommended include identifying mechanisms for:

- facilitating service provision from County Boards of Mental Retardation and Developmental Disabilities for all persons with developmental disabilities
- addressing the issues of multiple standards and licensing requirements
- enabling group homes in becoming eligible for HUD Sec. 8 rent subsidies
- collecting data on low incidence developmental disabilities

- effectively disseminating results and products of DD funded projects
- advocating for services for persons with developmental disabilities who are not substantially handicapped
- coordinating across all major state agencies and using federal monies under the DD legislation to "force" coordination
- use of State Library system for DD public awareness materials and campaigns, dissemination of products of DD funded projects, and DD information and referral on services

OHIO DEVELOPMENTAL DISABILITIES PLANNING COUNCIL

CHILD DEVELOPMENT COMMITTEE

PREVENTION CHART

This chart was compiled in accordance with a 1983 State Plan Objective, "to describe the elements of a prevention system, existing services for the prevention of developmental disabilities, and gaps in, or the non-existence of services for the prevention of developmental disabilities in Ohio." The chart includes only those programs and services offered statewide or region-wide by government agencies. The Child Development Committee used this chart as a planning tool to assist it in developing objectives for the 1984-86 State Plan for Developmental Disabilities.

OHIO DEVELOPMENTAL DISABILITIES PLANNING COUNCIL
CHILD DEVELOPMENT COMMITTEE

PREVENTION CHART

ELEMENTS FOR A PREVENTION SYSTEM	PROGRAM NAME	DESCRIPTION	ESTIMATED NUMBER SERVED	ESTIMATED NUMBER UNSERVED	SERVICE GAPS
PRECONCEPTION *Definition: Services targeted toward the health and well-being of potential parents in order to minimize the risk of disabilities among their offspring.* *Elements:* *1. Services for identification of families and individuals at risk for mental retardation and developmental disabilities.* *A. Biological*					
• *Genetic factors*	Ohio Department of Health Genetics Services Network	Six Genetic Centers and three satellite clinics provide counseling, diagnosis and treatment including lab services such as amniocentesis, chromosome analysis and syndrome identification, as well as providing education and referrals.	11,863 children and/or families were served at the nine Ohio Genetic Clinics (1981)	1,132,589 (Estimated that 10% of the general pop. are potential clients while only 3.3% are served) Only 30% of women over 35 have amniocentesis.	• Low usage, especially by low-income, minority and rural populations • Health professionals may be unaware of service and thus patients remain unaware.

ELEMENTS FOR A PREVENTION SYSTEM	PROGRAM NAME	DESCRIPTION	ESTIMATED NUMBER SERVED	ESTIMATED NUMBER UNSERVED	SERVICE GAPS
PRECONCEPTION					
A. *Biological* • *Genetic factors (continued)*	Ohio Department of Health Genetic Services Network	Sickle Cell Program provides screening, counseling and education for persons with, at risk for, or carriers of, Sickle Cell Disease through 9 project service sites.	Screened: 3,613 individuals Counseling: 436 families Public Education: · 13,095 individuals	Target pop. for Sickle cell in Ohio: 1,156.077, (1981)	• Services not available throughout the State.
• *Rubella immunization*	Ohio Department of Health Rubella Immunization Program	ODH provides vaccine to local health departments and certain pediatric/children's hospitals. State law requires that all children in day care centers and grades K-12 have rubella vaccination unless: 1) religious or philosphical objection 2) physician feels it may be harmful 3) not required for post pubescent age females	Overall average of all school age children: 96.8% with 1.9% exempt. Average for all 1st graders: 99.6% Average for all 12th graders: 89.2%	1.3% (may be less since this includes "no record" of immunity status on school records) NOTE: Reported cases of congenital rubella syndrome in Ohio were: 1978 - 0 1979 - 3 1980 - 3 1981 - 0	• No requirement in Ohio for premarital rubella screening • Many physicians do not encourage women of childbearing age to become vaccinated for fear of repercussions in the event the patient might be pregnant.

ELEMENTS FOR A PREVENTION SYSTEM	PROGRAM NAME	DESCRIPTION	ESTIMATED NUMBER SERVED	ESTIMATED NUMBER UNSERVED	SERVICE GAPS
PRECONCEPTION B. *Environmental* • *Lower socio-economic strata*					
• *Adolescent pregnancy*	Ohio Department of Health Family Planning Program	One of 4 grantees in Ohio that receive federal (Title X) funds. The three other major family planning service providers in Ohio are, the Federation for Community Planning - Cleveland (serves 5 counties), Planned Parenthood of Summit County (serves 2 counties) and Planned Parenthood of Central Ohio (serves 6 counties). A total of 84 counties in Ohio have family planning clinics. These clinics provide counseling, education, medical services and contraceptive supplies. Service emphasis is placed on high risk clients, including TEENS and women over 35, low-income, and persons at high medical risk.	168,394	421,394 Estimated by taking the number of women aged 15-44 yrs, who are 1) fecund, 2) sexually active and 3) below 200% of poverty = 590,210, subtracting the number of women served.	• Services are not uniformly available throughout the State. • At state level, budget cuts prevent expansion of existing services to those areas currently without services. • At local level, lack of community support and/or knowledge prevent expansion.
	University Affiliated Cincinnati Center for Developmental Disorders Adolescent Clinic and Adolescent DD Program	Provides interdisciplinary diagnosis/treatment services to adolescents which include studies of rubella immunizations, family planning services, contraception, education, and referral for adolescents related to prenatal care.	Approx. 1,175* visits to the program per year in ADD program. Many more in adolescent clinic. *Indicates total # of individuals served or total # of visits.	Unavailable	• Does not meet total needs of the region. • Operates through grant funding and if the grants are cut/eliminated, services will not be able to be continued through fees for services.

ELEMENTS FOR A PREVENTION SYSTEM	PROGRAM NAME	DESCRIPTION	ESTIMATED NUMBER SERVED	ESTIMATED NUMBER UNSERVED	SERVICE GAPS
PRECONCEPTION *B. Environmental*					
• *Alcohol abuse*	Ohio Department of Health Alcohol Abuse Program	141 Alcohol treatment programs serve all counties in Ohio. 84 are out-patient programs. 57 have beds and 24 of these are detoxification programs. All provide treatment, which consists primarily of individual and group counseling. Public education and information program specialists make a special thrust re. Fetal Alcohol Syndrome.	30,388 (# of carry-overs from previous years plus admissions)	Unavailable	• Not enough services for female alcoholics. • Need intermediate care facilities between detoxification & return to community. These would be non-medical but supervised.
• *Drug abuse*	Ohio Department of Education Substance Abuse Program	Curriculum development and consultation regarding program development and implementation provided to local school systems and communities. Several years ago, curriculum was developed for all grade levels; student books and teacher manuals were provided to all schools.	Unavailable	Unavailable	• Program has been cut from 5 staff people to 1 part-time person. • Schools could not be mandated to use the materials.

ELEMENTS FOR A PREVENTION SYSTEM	PROGRAM NAME	DESCRIPTION	ESTIMATED NUMBER SERVED	ESTIMATED NUMBER UNSERVED	SERVICE GAPS
PRECONCEPTION					
B. Environmental					
• Single parent family					
• Mental health					
2. Service delivery system					
A. Genetic counseling		See Genetics Services Network			
B. Family planning		See Family Planning Program			
C. Services related to socio-economic conditions					
• Income maintenance	Ohio Department of Public Welfare Aid to Dependent Children Program	Offers financial assistance to children who have a parent who is absent from the home, unemployed, physically or mentally incapacitated, or deceased. Monthly gross income must be less than 150% of Ohio's standard of need, which varies according to size of the household. Resources (other than auto and house) must be less than $1,000. Examples of grants are: 1 person - $111 2 people - $216 3 people - $263	197,504 cases 590,764 people	Unavailable	• Pregnant women with no other children cannot receive a cash assistance payment until the sixth month of pregnancy.

ELEMENTS FOR A PREVENTION SYSTEM	PROGRAM NAME	DESCRIPTION	ESTIMATED NUMBER SERVED	ESTIMATED NUMBER UNSERVED	SERVICE GAPS
PRECONCEPTION 2. *Service delivery system* C. *Services related to socio-economic conditions*					
• *Income maintenance (continued)*	Ohio Department of Public Welfare General Relief Program	Funded by the state and the 88 counties. Provides financial and medical assistance to those who do not meet eligibility for other programs.	101,349 cases 111,107 people	Unavailable	• Amount of assistance varies by county.
• *Access to medical care*	Ohio Department of Public Welfare Medicaid Program	Designed to provide health care to persons who are eligible to receive cash payments under one of the existing welfare programs or meet eligibility requirements determined by the state-approved plan. Eligible groups include: ADC families, low-income blind, disabled and older persons. Services provided include: • inpatient and outpatient hospital services • home health care • services of physicians, dentists, optometrists, and other licensed specialists • clinic services • physical, speech and occupational therapy • family planning	737,417 persons are eligible to participate. This # includes 590,764 ADC recipients. The remainder are SSI recipients.	Unavailable	• Lack of information to clients - often pregnant women do not realize that they may receive Medicaid, even though they cannot receive cash assistance until the third trimester. • Lack of public education re need for early prenatal care.

ELEMENTS FOR A PREVENTION SYSTEM	PROGRAM NAME	DESCRIPTION	ESTIMATED NUMBER SERVED	ESTIMATED NUMBER UNSERVED	SERVICE GAPS
PRECONCEPTION					
2. *Service delivery system*					
C. *Services related to socio-economic conditions*					
• *Access to medical care (continued)*	Ohio Department of Public Welfare Medicaid Program	Pregnant women who are eligible for Medicaid may receive all the services listed above. A woman who meets eligibility requirements for ADC will not receive a cash assistance payment until the third trimester, but is eligible for Medicaid upon confirmation of her pregnancy.			
• *Nutrition*	Ohio Department of Public Welfare Food Stamp Program	Provides food coupons to eligible individuals and families to buy food. Eligible households must have low income and few resources. Physically and mentally handicapped people do not have to meet the work registration requirement.	Over 1 million	Unavailable	• Lack of public education

ELEMENTS FOR A PREVENTION SYSTEM	PROGRAM NAME	DESCRIPTION	ESTIMATED NUMBER SERVED	ESTIMATED NUMBER UNSERVED	SERVICE GAPS
PRECONCEPTION 1. *Service Delivery System* C. *Services related to socio-economic conditions* • *Nutrition (continued)*	Ohio Department of Health Women, Infants and Children Nutrition Program (WIC)	WIC is the primary provider of preventive nutrition services available through the Ohio Department of Health. Nutrition services available through WIC include nutrition education and counseling, food, and referral to other health and Social Services. WIC services are available in 85 of Ohio's 88 counties. In addition, nutrition services are available through the following ODH administered programs: 1. Perinatal 2. Child health 3. Family planning	Approximately 89,000 low-income and nutritionally at risk pregnant, post-partum and breast-feeding women, infants, and children less than 5 years old as of March 1982.	126,143 women, infants and children are potentially eligible (as of March 1982) and are not being served.	• Unavailable in three counties: Madison, Geauga and Carroll. • Lack of public awareness of service. • Inadequate administrative funds. • Lack of health services in communities to which WIC is to be an adjunct. • Nutrition education component is needed by all socio-economic groups, not just poverty level population.

ELEMENTS FOR A PREVENTION SYSTEM	PROGRAM NAME	DESCRIPTION	ESTIMATED NUMBER SERVED	ESTIMATED NUMBER UNSERVED	SERVICE GAPS
PRECONCEPTION					
2. *Service Delivery System*					
D. *Expanded family life education*	Ohio Department of Education Family Life Education Program	Education programs for homemakers (men and women) in economically distressed areas of Ohio. Parents of infants and young children are a special target group for Parent Education programs. One aspect is a parent/infant interaction program for parents of infants to children aged three. Some classes are also offered in nutrition, parent self-concept and communication skills.	9,682 adults (14% are under age)	50,000	● Programs are in process of being severely cut due to budget revisions.
	Ohio Department of Public Welfare Title XX Program	The following services are provided to eligible families and individuals (receiving ADC, ADC-U or income eligible):		Unavailable (There are approx. 250,000 households with children below poverty level, according to ODH reports).	● Staff shortages
		Counseling	62,651		
		FAMILY LIFE EDUC.............	1,621		
		Family Planning	30,396		
		Health Related	18,203		
		Transportation	53,925 (1981)		
		Services are provided at local level through county welfare agencies, often via contract with other community service agencies.			

ELEMENTS FOR A PREVENTION SYSTEM	PROGRAM NAME	DESCRIPTION	ESTIMATED NUMBER SERVED	ESTIMATED NUMBER UNSERVED	SERVICE GAPS
PRECONCEPTION 2. *Service Delivery System* E. *Ensuring a health system responsive to the needs of high risk groups*	Ohio Department of Health Sexually Transmitted Disease Program	Most county and city health department provide screening, diagnosis, treatment, follow-up and outreach for persons with sexually transmitted diseases. Those health departments that do not provide all or some of the above-mentioned services make referrals to other health care providers including private physicians, hospital emergency rooms, Planned Parenthood affiliates.	2,225,000 individuals were screened or visited STD Units for treatment (1979)	Unavailable - unknown how many in general population were seen by private physicians, or alternate service providers.	• Public schools vary in quality, regularity, uniformity of venereal disease education. • Repeat victims are often unconcerned about preventing VD. • General lack of knowledge re causes, prevention and seriousness of sexually transmitted diseases.
	March of Dimes	Provides free public education brochures, and films, continuing education modules for nurses, and professional education materials for physicians and educators. Funds medical service grants on regional basis. Provides I&R for patients.	Unavailable	Unavailable	

ELEMENTS FOR A PREVENTION SYSTEM	PROGRAM NAME	DESCRIPTION	ESTIMATED NUMBER SERVED	ESTIMATED NUMBER UNSERVED	SERVICE GAPS
PERINATAL *Definition: Services which promote the health and well-being of pregnant women and newborns (up to one month) in order to minimize the risk of morbidity.* *Elements* 1. *Identification of High Risk Groups* A. *Biological* • *Adolescent pregnancy* • *Mothers over 35 years of age* • *Families with known genetic disorders* • *Previous complications*	Ohio Department of Health Genetics Services Network	Six Genetic Centers and three satellite clinics provide counseling, diagnosis and treatment including lab services such as amniocentesis, chromosome analysis, and syndrome identification, as well as providing education and referrals. Centers are located in medical schools, medical centers, rehabilitation centers and university affiliated programs.	11863 children and/or families were served at the nine Ohio Genetic Clinics (1981)	1,132,589 need genetic counseling	• Low usage, especially by low-income, minority and rural populations. • Doctors may be unaware of service, thus patients remain unaware.
• *Alcohol abuse* • *Drug abuse* • *Radiation* • *Smoking* • *Prescribed Drugs* • *Environmental hazards*					

ELEMENTS FOR A PREVENTION SYSTEM	PROGRAM NAME	DESCRIPTION	ESTIMATED NUMBER SERVED	ESTIMATED NUMBER UNSERVED	SERVICE GAPS
PERINATAL					
1. *Identification of High Risk Groups* *A. Biological*					
• *All known birth complications*	Ohio Department of Health Newborn Screening Program	All newborns are screened at birth for hypothyroidism, homocystinuria, galactosemia and phenylketonuria (PKU). The Ohio Department of Health provides dietary supplements for infants diagnosed with PKU.	Approximately 165,000 newborns each year. In 1981 there were 10 children identified w/PKU and started on dietary supplements; 30 diagnosed with hypothryoidism		
B. Environmental					
• *Nutrition*	ODH WIC Program				
• *Mental health*					
• *Rural/Inner city access to services*					

ELEMENTS FOR A PREVENTION SYSTEM	PROGRAM NAME	DESCRIPTION	ESTIMATED NUMBER SERVED	ESTIMATED NUMBER UNSERVED	SERVICE GAPS
PERINATAL 1. *Identification of High Risk Groups* B. *Environmental*					
● *Lower socio-economic strata*	ODPW Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT)	An on-going health maintenance program for children aged 0 to 21 who are Medicaid eligible. Purpose is to improve health status of poor/needy children through early detection and treatment of disease and disability. Recommended once a year or at least at ages 1,4,11,16. Provides the following screening procedures: physical examination; screening for immunization status, eye problems, hearing; urinalysis; developmental screening; growth assessment; screening for tuberculin sensitivity, bacteriuria, anemia, lead poisoning, sickle cell diseases; nutritional assessment, other lab tests.	68,660 participated in EPSDT in calender year 1981. This # includes 54,260 newly screened and 14,400 newborn or infant screenings.	Approx. 381,000 (on a given day, the average # of Medicaid eligible individuals in Ohio who are under age 21 and eligible for EPSDT is 450,000)	● Parents must make an active decision to participate in EPSDT. ● Range of services may vary at local leval based on local funding (match), coordination, commitment and timely reimbursement histories. ● Lack of community awareness. ● Attitudinal problems re. welfare system. ● Only 1/5 of medicaid providers are participating in EPSDT.

ELEMENTS FOR A PREVENTION SYSTEM	PROGRAM NAME	DESCRIPTION	ESTIMATED NUMBER SERVED	ESTIMATED NUMBER UNSERVED	SERVICE GAPS
PERINATAL					
2. *Service Delivery System*					
A. *Prenatal diagnosis and care*	Ohio Department of Health Prenatal Care Program	Maternal health programs to provide comprehensive care to mothers throughout the maternity cycle. Service emphasis given to education and preventive health. Services available in slightly less than 1/3 of Ohio's counties. The levels of care range from minimum services by public health nurses (history, examination, laboratory, counseling and education) to comprehensive services for the mother and infant. Includes the Improved Pregnancy Outcome project and three Maternal and Infant Care Projects. Prenatal care facilities are established in counties based on the mortality and morbidity rates, and funded through a combination of federal, state and local dollars.	6,280 women received prenatal care. 3,779 babies delivered (24 clinics reported - 1981) * * * * * M & I Projects reported: 6,744 women received prenatal care 4,458 babies delivered	3,368 women (out of 168,745) did not indicate any prenatal care on birth certificate (1980) Over 1,000 women were "walk-ins", i.e., had not been seen, beyond a pregnancy confirmation visit, prior to delivery.	• 62 counties do not have ODH funded prenatal care clinics (though there may be prenatal clinics present that are funded through other sources). • Some counties with the need for prenatal services do not have the local community support necessary to establish these clinics.
B. *Education*		See March of Dimes			
C. *Nutrition*		See WIC Program			

ELEMENTS FOR A PREVENTION SYSTEM	PROGRAM NAME	DESCRIPTION	ESTIMATED NUMBER SERVED	ESTIMATED NUMBER UNSERVED	SERVICE GAPS
PERINATAL I. *Service Delivery System* D. *Screening systems*	Ohio Department of Health Bureau of Crippled Children's Services (BCC (BCCS)	Identifies and diagnoses potentially handicapped children, provides treatment to financially eligible children from birth to age 21 who have handicapping conditions. Diagnostic services are provided without regard to family income. Treatment for eligible handicapping conditions requires the family to meet income eligibility criteria. Eligible handicapping conditions are not listed per se, so that policies for care are determined by each individual diagnosis. No acute or primary care is provided. Services that are provided include: surgeries, braces, medical equipment, X-rays, lab tests, glasses, medication PT and OT. Comprehensive Care Centers are located in Cincinnati, Akron, Cleveland, Columbus, Dayton, and Toledo, at which team evaluations may be performed on referred children.	37,500 children aged 0-21 (1981)	Approximately 5,000-7,000 potentially eligible individuals are "lost" when they do not return economic evaluation forms - service is not provided because financial eligibility was not established. Exact information on number of handicapped children who are not served is unavailable.	• Approximately one out of every four children who are identified as potentially eligible, and who receive economic evaluation forms, do not return the necessary paperwork. • Lack of follow-up: families may be receiving no service or duplicate services, but the Bureau has no way of tracking this. • Lack of services to all chronically handicapped children.

ELEMENTS FOR A PREVENTION SYSTEM	PROGRAM NAME	DESCRIPTION	ESTIMATED NUMBER SERVED	ESTIMATED NUMBER UNSERVED	SERVICE GAPS
PERINATAL					
2. Service Delivery System					
D. Screening systems	Nisonger Center	The Hearing Screening Program works in conjunction with the Level III nursery at University Hospital to conduct hearing, screening on all at risk infants prior to release and performs more comprehensive diagnosis on infants who fail the initial screening.	Approx. 80	Unavailable	
E. Regionalized system of perinatal services	Ohio Department of Health Perinatal Regionalization Program	High risk obstetrical and neonatal care for high risk mothers and newborns. Facilities are partially funded by the Ohio Dept. of Health in the 6 perinatal regions: Akron, Cleveland, Columbus, Toledo, Cincinnati, Dayton. The system is designed to incorporate education, transportation and referral to make quality care available throughout the state.	Number of individual patients served is unavailable. Outreach perinatal education programs were provided to: 403 hospitals 43 health depts. 100 consumer agencies	Unavailable	Regional Perinatal coordinators must return to hospitals and repeat training because staff turnover may be frequent.

ELEMENTS FOR A PREVENTION SYSTEM	PROGRAM NAME	DESCRIPTION	ESTIMATED NUMBER SERVED	ESTIMATED NUMBER UNSERVED	SERVICE GAPS
PERINATAL					
2. Service Delivery System					
F. Counseling					
G. Sensitivity to parent-child interaction					
H. Metabolic treatment programs	UACCDD Metabolic Disorders Treatment Program	Provides interdisciplinary evaluation/management of individuals with or suspected of having metabolic disorders. Services include dietary Management of PKU.	90*	Unavailable	• Does not meet total needs of the region. • Operates on grant funding.
I. Hypothyroid treatment program/ pediatric endocrinology					
J. Other treatment programs	UACCDD	Myelomeningocele program provides consistent comprehensive, interdisciplinary evaluation and treatment services to children with MM and related conditions.	200* *Indicates total number of individuals served or total number of visits.	Unavailable	

ELEMENTS FOR A PREVENTION SYSTEM	PROGRAM NAME	DESCRIPTION	ESTIMATED NUMBER SERVED	ESTIMATED NUMBER UNSERVED	SERVICE GAPS
PERINATAL 2. *Service Delivery System* *K. Referral systems*	UACCDD High Risk Follow-up Liaison/ Screening Program	Serves as a linkage among high risk neonatal intensive care units, UACCDD, and early intervention programs providing interdisciplinary diagnostic, treatment, and follow-up services to "high risk neonates" who have signs of developmental problems. Consultation, in-service training is also provided to staff of neonatal intensive care units.	Approx. 200* Referral section	Unavailable	Does not meet total needs of region. Operates through grant funding.
	Nisonger Center/ Children's Hospital High Risk Follow-up Program	Provides developmental follow-up of selected infants served by the Level II nursery at Children's Hospital and links infants and families with special needs to appropriate Nisonger and community agencies.	Approx. 100	Unavailable	

ELEMENTS FOR A PREVENTION SYSTEM	PROGRAM NAME	DESCRIPTION	ESTIMATED NUMBER SERVED	ESTIMATED NUMBER UNSERVED	SERVICE GAPS
PERINATAL 2. *Service Delivery Systems* *b. Other support systems (e.g. parent-to-parent programs)* *3. Accessibility of services* *4. Knowledge of services available*					

ELEMENTS FOR A PREVENTION SYSTEM	PROGRAM NAME	DESCRIPTION	ESTIMATED NUMBER SERVED	ESTIMATED NUMBER UNSERVED	SERVICE GAP
ONE WEEK THROUGH FOUR YEARS *Definition: Services which promote the health, safety and well-being of children one week through four years of age in order to prevent the manifestation of disabilities.* *Elements:* • *No obvious organic problems with and without obvious socio/economic/sociological problems.* *I. Diagnostic assessment and follow-up of high risk infants*					
A. Medical/health related • *Routine pediatric supervision* • *Nutrition supplements*	Ohio Department of Health Child Health Services	Under Block Grant Legislation, the Bureau of Maternal and Child Health, Ohio Department of Health, is funding thirty-five (35) Child Health Projects two Children and Youth Projects and three Lead Poisoning Prevention Programs. There is also one specialty project: Children's Neuromuscular Program - Cincinnati Center for Developmental Disorders.	Approximately 49,000 children were served by the Bureau of Maternal and Child Health funded Comprehensive Child health Projects in thirty-three counties.	Unavailable	• MCH funded Comprehensive Health Servic are unavailabl in fifty-five (55) of Ohio's counties.

ELEMENTS FOR A PREVENTION SYSTEM	PROGRAM NAME	DESCRIPTION	ESTIMATED NUMBER SERVED	ESTIMATED NUMBER UNSERVED	SERVICE GAPS
ONE WEEK THROUGH FOUR YEARS					
1. A. *Medical/health related (continued)*	Ohio Department of Health Child Health Services (continued)	Lead Poisoning Prevention Programs provide assessment, identification, referral and environmental correction for children ages 1-16 at risk for undue lead absorption/toxicity in three cities. Children's Neuromuscular Program offers a continuum of care for clients from birth to adolescence by providing a full range of interdisciplinary services for the habilitation or rehabilitation of individuals with developmental disabilities and related handicapping disorders.			• Gaps occur between child health services and other local human service organizations due to weak referral and follow-up components.
• *Developmental screening*					
B. *Enviornmental* • *Home assessments* • *Counseling support*					

ELEMENTS FOR A PREVENTION SYSTEM	PROGRAM NAME	DESCRIPTION	ESTIMATED NUMBER SERVED	ESTIMATED NUMBER UNSERVED	SERVICE GAPS
ONE WEEK THROUGH FOUR YEARS					
I. B. *Environmental* • *Protective services*	Ohio Department of Public Welfare Children's Protective Services	The Children's Protective services Unit administers project activities under federal Child Abuse and Neglect grant funds. Although the Unit delivers no direct services, it is responsible for the establishment and administration of the state registry for child abuse and neglect. In addition, the Unit administers and supervises the direct care projects located in each of Ohio's 88 counties either in the form of a County Board of Welfare or a Children's Services Board (in Ohio presently are 40 CSBs and 48 CBWs). These Boards provide "what ever services are necessary to protect the child" including 24 hour emergency services, emergency shelter and protective in-home services.	15,114 cases reported 5,736 cases substantiated as neglect or abuse.	21,750 - 45,000 children (0-18) (Figure arrived at by incidence figures which suggest that 1.3 to 2.1 of every 100 children are abused or neglected)	• Many cases of abuse go unreported due to witnesses not knowing what constitutes abuse; not knowing reporting procedures; not knowing that there is a place to which abuse can be reported; reporting once and having no results and not reporting again. • Sometimes abuse cannot be substantiated. • If parents do not want help for themselves or their children, they can only be forced to comply through court action. • High staff turnover leads to lack of follow-up.

ELEMENTS FOR A PREVENTION SYSTEM	PROGRAM NAME	DESCRIPTION	ESTIMATED NUMBER SERVED	ESTIMATED NUMBER UNSERVED	SERVICE GAPS
ONE WEEK THROUGH FOUR YEARS • *For children with obvious or questionable organic problems* 1. *Follow-along services* • *Comprehensive diagnostic assessment* • *Development and implementation of a plan* • *Case management and referral*	Nisonger Center	The comprehensive interdisciplinary clinic provides diagnostic, assessment, and program planning services to aid in the development of individualized program plans. The Nutrition/Feeding Clinic offers interdisciplinary assessment and intervention with young developmentally delayed children who have feeding and/or growth problems and their families. Neuromotor Clinic provides interdisciplinary assessment and early intervention with young children who have motor delays or dysfunctions. The Early Childhood Program, an alliance between Nisonger Center and the Franklin County Board of MR/DD, provides interdisciplinary educational and therapeutic services to developmentally delayed children and their families. The Myelomeningocele Clinic offers interdisciplinary services to children with myelomeningocele from birth through age 21. The Dental Program provides preventive	Approx. 1,220	Unavailable	

ELEMENTS FOR A PREVENTION SYSTEM	PROGRAM NAME	DESCRIPTION	ESTIMATED NUMBER SERVED	ESTIMATED NUMBER UNSERVED	SERVICE GAPS
ONE WEEK THROUGH FOUR YEARS					
1. *Follow-along services (continued)*	Nisonger Center (continued)	and therapy programs. The Audiology Program conducts screening, diagnosis and assessment of children at risk or with suspected hearing impairment and provides hearing aids or other intervention when necessary.			
	Department of Mental Retardation/Developmental Disabilities and County Boards of Mental Retardation and Developmental Disabilities	Promotes comprehensive statewide programs and services for the mentally retarded and their families wherever they reside in the state. Programs include public education and prevention. Much of the prevention work done by County Boards of MR/DD is the result of the provision of infant stimulation, pre-school and supportive home services.	Infant Stimulation Classes (0-2): 803 Pre-School Classrooms (0-4): 1070 Supportive Home Services (0-2): 418 Supportive Home Services (3-4): 115 (September, 1982)		

ELEMENTS FOR A PREVENTION SYSTEM	PROGRAM NAME	DESCRIPTION	ESTIMATED NUMBER SERVED	ESTIMATED NUMBER UNSERVED	SERVICE GAPS
ONE WEEK THROUGH FOUR YEARS					
1. *Follow-along services (continued)*	UACCDD	Services are prpvided as indicated, through metabolic disorders treatment program, UACCDD High Risk Follow-up liaison/screening program and UACCDD MM program.			Do not meet total needs of the region. Grant funding.
		UACCDD provides: (1) comprehensive interdisciplinary evaluations to approx. 25 children under 1 yr. of age and approx. 200 children from 1 to 4 yrs. as a basis for the development of individualized plans to maximize child's potential: (2) dental therapy to approx. 500* clients, and (3) linkages are established with public health nurses for ongoing care follow-up for approx. 175* clients.	Evaluations: 25 under 1 yr. of age 200 - 1 to 4 yrs. Dental Therapy: 500* Linkages for Follow-up: 175*		
		UACCDD Cerebral Palsy program provides consistent, comprehensive interdisciplinary evaluations and treatment services to approximately 300* children with CP and related conditions.	CP Program Evaluations: 300*		
		UACCDD preschool Observation/Diagnostic classroom provides opportunity for extended, intensive diagnostic observations of approx. 60* complex cases.	Diagnostic Observations: 60* *Indicates total # of individuals served or total # of visits.		

ELEMENTS FOR A PREVENTION SYSTEM	PROGRAM NAME	DESCRIPTION	ESTIMATED NUMBER SERVED	ESTIMATED NUMBER UNSERVED	SERVICE GAPS
ONE WEEK THROUGH FOUR YEARS					
I. *Follow-along services (continued)*	Ohio Department of Health Speech, Hearing and Vision Screening	Designed to provide, at no cost, screening and diagnosis with limited treatment, for speech, hearing, and vision problems. Training and consultation are also provided to schools and local health departments to provide screening. Attempts are presently being made to establish newborn auditory screening for infants found in third level tertiary units, which tend to serve infants born under stress, who may be "at risk" for hearing problems.	Hearing Screening: 7,300 Aged 0-21 Vision Screening: 2,000 Aged 0-21 Screened and/or diagnosed and/or treated for Speech problems: 13,000 Aged 0-21 (1981)	Unknown how many children are seen by private service providers. Incidence figures indicate that of all 0-4 year olds, 2% (about 19,000 could be expected to have hearing problems, 7% (about 58,000) could be expected to have vision problems, and 3% (28,000) could be expected to have speech problems.	• No mechanism for mass screenings of children between ages of one and five. • Lack of follow-up information. It is not known which children are being referred once their problems are identified and which are not. • Most of speech therapy is not paid for by 3rd party sources, because speech problems must be treated with on-going therapy rather than medical methods.

ELEMENTS FOR A PREVENTION SYSTEM	PROGRAM NAME	DESCRIPTION	ESTIMATED NUMBER SERVED	ESTIMATED NUMBER UNSERVED	SERVICE GAPS
ONE WEEK THROUGH FOUR YEARS					
2. *Genetic counseling*		See Genetic Services Network			
3. *Prevention*					
• *Immunization*		See Immunization Program			
• *Lead poisoning*		See Lead Poisoning Program			
• *Other poisoning*					
• *Accident prevention*					

CONCEPT PAPERS DEVELOPED BY EARLY INTERVENTION TASK FORCE MEMBERS ANALYZING THE FOLLOWING PROGRAM COMPONENTS OF A COMPREHENSIVE EARLY INTERVENTION PROGRAM

CHILD FIND
INTERDISCIPLINARY DIAGNOSIS AND ASSESSMENT
INDIVIDUAL TREATMENT OR HABILITATION PLAN
COMPREHENSIVE SERVICES
CONSUMER INVOLVEMENT
FOLLOW ALONG
EVIDENCE OF PROGRAM EFFECTIVENESS
STAFF TRAINING
THEORETICAL ADEQUACY AND CONSISTENCY
FAMILY SUPPORT
CASE MANAGEMENT

OHIO DEVELOPMENTAL DISABILITIES PLANNING COUNCIL

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INTRODUCTION

In order to develop the Ohio Developmental Disabilities Planning Council State Plan for early intervention services, ('84-87) an Early Intervention Task Force was formed. The Task Force included persons representing State Departments with legislative mandates to provide services to children, 0-4, with developmental delays. Local service providers, physicians, parents, and University representatives broadened the scope and increased the credibility of the task force. Some of the members were also participants in the Early Childhood Committee of Council and/or the Council.

The Early Intervention Task Force adopted the following outline as its mission statement, goals, and objectives:

Mission - The Early Intervention Task Force has been established to promote the availability of comprehensive early intervention services for children 0-4 years in Ohio who are in need of these services. It will examine barriers to the delivery of early intervention services and develop recommended strategies to eliminate these barriers to the Child Development Committee.

1) To define and describe components of comprehensive early intervention services.

   OBJECTIVE:

   1.1 Provide a written report of findings to the Child Development Committee.

2) To promote the value and need for early intervention programs in Ohio for children 0-4 years.

   OBJECTIVES:

   2.1 Examine available literature and existing model programs for the "state of the art" on early intervention services.
   2.2 Review available cost-benefit data on early intervention services.

3) To identify funding resources, availability of programs and gaps in early intervention services in Ohio.

   OBJECTIVES:

   3.1 Provide liaison with grant funded to examine financial resources and availability of early intervention services.
   3.2 Review and utilize reports generated by grant.

4) To identify issues and/or barriers preventing development and maintaince of early intervention services at the local level.

   OBJECTIVES:

   4.1 Examine responsibilities, services, and problems of appropriate state and private agencies in providing early intervention services.
   4.2 Identify needed public and professional education on early intervention services.

5) To identify strategies to eliminate issues and/or barriers which prevent development and maintenance of comprehensive early intervention programs in Ohio.

OBJECTIVES:

5.1 Prepare a report of findings for presentation to the Child Development Committee.
5.2 Prepare draft documents identifying goals, objectives, and strategies for presentation to the Child Development Committee for consideration of inclusion in the 1984-87 Developmental Disabilities Planning Council State Plan.

The Frank Porter Graham Child Development Center located at the University of North Carolina at Chapel Hill has produced a series of topical papers on developmental disabilities. One of the papers in this series, A Compendium of Exemplary, Comprehensive Programs for Young Developmentally Disabled Children, by Marie M. Bristol and Joan M. Bartel, describes 10 critical elements of comprehensive early intervention delivery systems for young developmentally disabled children and their families.

The DD Council Early Intervention Task Force has adopted these 10 components and added the component of family support as being representative of the definition of comprehensive early intervention services. The 11 components of comprehensive early intervention services are as follows:

1) Child find--A coordinated mechanism for identifying potential clients, assessing needs, and locating appropriate services to meet client needs. This would include a mechanism for an initial screening or brief assessment that would identify children in need of further evaluation, and possibly intervention.

2) Interdisciplinary diagnosis and assessment--A coordinated evaluation by a team of specialists from a variety of fields who assess the status and function of the child in all major developmental areas. Such an assessment team might include a psychologist, a physician, an educator, a social worker, a speech therapist, a physical therapist, and other professionals with training and experience relevant to both the child's and family's needs.

3) Individual treatment or habilitation plan--A plan written with parental input and consent which usually specifies strengths and weaknesses of the child, present level of functioning, specific long and short range objectives for programming, and provides for periodic reevaluation and revision. The plan may be called an Individual Treatment, Habilitation, Education, Service, or Program Plan depending on the sponsoring agency.

4) Comprehensive services--A full range of programmatic services designed to meet the individual client's needs provided through coordination or integration of services among multiple service providers.

5) Consumer involvement--Opportunities for active involvement of parents in all phases of program operation including both the design and evaluation of programs for their individual child and significant input into overall program design and evaluation.

6) Follow along--A formal mechanism to ensure that the child actually receives needed additional services provided outside the scope of an individual program. These services may be provided either concurrently with ongoing treatment or through referral or transfer to another agency at the time of termination of primary service responsibility.

7) Evidence of program effectiveness--Some systematic evidence in addition to monitoring of individual child progress which shows that the overall program is effective in facilitating the progress of groups of children.

8) Staff training--Evidence that program staff have appropriate and sufficient training and experience to meet client needs and that continuing in-service training is provided to maintain and upgrade staff knowledge and skills.

9) Theoretical adequacy and consistency--Evidence that the treatment program represents a consistent programmatic approach based on the best available knowledge regarding the prevention, amelioration, or rehabilitation of processes which cause or complicate developmental disabilities in young children.

10) Family support--The availability of all necessary support services to the family of the participating child. This would include: Parent to parent support groups (Parents as Partners), mental health counseling, marriage counseling, home visits, parenting training, respite care, incorporation of whole family into lesson plans or occasionally classroom experiences, utilizing parents knowledge in designing child's individual education plans.

11) Case management system--The assignment of a specific person responsible for assuring, documenting, and evaluating continuity of care for an individual developmentally disabled person throughout all phases of treatment both within a given agency and across agencies. This person may be located either within or outside the service providing agency or agencies. The case management system should allow for review and redirection throughout the life span of the client as well as provide standby availability to assist the individual with unanticipated problems while not fostering dependency on the part of the developmentally disabled person.

CHILD FIND

Mandates--P.L. 94-142, Rules and Regulations 300.128 (Identification, Location, and Evaluation of Handicapped Children); 300.750 (Annual Report of Children Served); 300.220 (Child Identification);

Rules for the Education of Handicapped Children (3301-51-02 A.1., 2., and 3. (Identification of Handicapped Children).

Procedures for Governance, Fiscal Management and Operation of Special Education Regional Resource Centers, Parts D. (Identification and Program Development Project) and E. (Educational Assessment Project);

3323.03 R.C. (Identification, Location, and Evaluation of Handicapped) and 3323.06 R.C. (State Plan).

P.L. 94-142 and the accompanying Rules and Regulations are federal mandates and therefore apply to all states.

Rules for the Education of Handicapped Children which became effective July 1, 1982, apply to every school district in the State of Ohio.

The entire State of Ohio is represented in one of the 16 Regional Resource Centers that must follow the procedures referenced above. Service Function I for the IPD project is the child identification program, including assistance to school districts in collecting child information from other agencies. Also included in this service function is the responsibility for the design and implementation of three year intensive awareness campaign as part of the out-of-school identification system. "Each school district shall document that an attempt was made to contact every household within the school district at least once during the campaign by mail, telephone, household visit, or other appropriate contact."

In the State of Ohio two departments with a major child find responsibility are the Department of Education and the Department of Mental Retardation and Developmental Disabilities. Section 3323.03 of the Ohio Revised Code states:

> "The State board of education shall, in consultation with the department of mental health and the department of mental retardation and developmental disabilities, establish standards and procedures for the identification, location, and evaluation of all handicapped children in the state, regardless of the severity of their handicap. No single method, device, or evaluation criterion shall be the sole criterion for determining an appropriate educational program for a handicapped child. The state board shall require the board of education of each school district, in consultation with the county board of mental retardation and developmental disabilities and the community health boards of each county in which the school district has territory to identify, locate, and evaluate all handicapped children residing within the district to determine which handicapped children are not receiving appropriate special education and related services.
>
> County boards of mental retardation and developmental disabilities and community mental health boards and their contract agencies may transmit to boards of education the names and addresses of handicapped children, who are not receiving appropriate special education and related services."

Range of Service--The full range of service is provided within each school district as mandated. The quality of the service varies among the various geographic areas. In one community a child with a suspected handicap may be identified, assessed, evaluated, and referred to a variety of appropriate program options. In another community the child may be identified, assessed, evaluated, and be referred to one program option with a waiting list.

Quality--The quality of each of the components of child find varies greatly across the state. The quality of services that a young handicap child and his/her family receives depends upon where the child lives in the state. As a rule, the rural communities are less aggressive in the child find process and fewer program options are available.

Gaps--It is very difficult to know the gaps in the child find component of comprehensive early intervention services. The grant attached to this Task Force regarding where the children who need services are located vs. where the services are located; and the prevalence of special needs children in comparison to actual children being served should provide this data.

We are aware of certain barriers to an efficient and effective child find system in the State of Ohio.

Barriers to a Comprehensive Child Find Process

1) Lack of a commitment on the part of the citizenry, the legislature, and public officials to a philosophy that amelioration and prevention of handicapping conditions in young children benefits the child, the family, and the community personally and economically.

   a) Some professionals in the appropriate position to identify and assess young handicapped children do not believe early intervention makes a difference in the child's development. Recent research efforts collaborate what other professionals have known for some time regarding the efficacy of early intervention services.

2) Some professionals lack the appropriate training to identify, locate, and evaluate young handicapped children appropriately. Professionals are reluctant to identify and assess developmentally delayed children even when they know "how to" because of the possibility of inappropriately labeling the child.

3) Although some states have recently mandated the provision of special education for handicapped children from birth, especially for the "severely handicapped", "in need of prolonged help" or low incidence handicapped areas, Ohio does not currently have such legislation. Section 3323.03 (B) R.C. states in part, ". . . and may provide for the educational placement of handicapped children at least three years of age . . ." Section 3323.07 R.C. states, "The state board of education shall authorize the establishment and maintenance of programs for the education of all handicapped children of compulsory school age, and may authorize such programs for handicapped children who are not of compulsory school age."

P.L. 94-142, 300.122 mandates ". . . ensure that a free and appropriate public education is available for all handicapped children aged 3 through 18 within the state not later than September 1, 1978, and for all other handicapped children aged 3 through 21 within the state not later than September, 1980." However, it contains the following exception [300.122(c)] "The requirement in paragraph (a) of this section does not apply to a state with respect to handicapped children aged 3, 4, 5, 18, 19, 20, or 21 to the extent that the requirement would be inconsistent with state law or practice, or the order of any court, respecting public education for one or more of those age groups in the state."

Rules for the Education of Handicapped Children 3301-51-03 A, 4 and 5, respectively state, "Approval for early childhood special education programs for identified handicapped children may be granted in accordance with an RFP . . ." and "A comprehensive program for handicapped children shall consist of instructional services at the elementary and secondary school levels and may include services at the preschool level."

Current Regulation 300.300(b)(3) states, "If a public agency provides education to 50 percent or more of its handicapped children in any disability category in any of these age groups, it must make a free appropriate public education available to all of its handicapped children of the same age who have that disability." (Rule 3301-51-01 T also makes this provision.) However, proposed Regulation 300.110 eliminates even that provision.

Rule 3301-51-01 T.5.d. states, "School districts may provide diagnostic services for handicapped children below three years of age and counseling to the parents."

The Department of Education provides educational services for handicapped children 5 through 21. The County Boards of Mental Retardation and Developmental Disabilities according to Amended Substitute Senate Bill 160 are to provide early childhood services according to a plan and priorities based upon available funds. The lack of a strong mandate to provide early childhood services impedes the identification, location, and evaluation processes for handicapped children 0 through 4 because of the lack of the availability of appropriate services once the children are identified. (This lack of mandate does not exist for County Boards of Mental Retardation and Developmental Disabilities.)

4) The child find process is further impeded by parents' general lack of knowledge of human growth and development. Parents may also be experiencing the need to deny that their child is not developing normally or may fear public ridicule and rejection. Unnecessary feelings of guilt may also cause delay for parents seeking services for their handicapped child.

5) The lack of and cost of transportation services is a barrier to an effective child find process. Parents may not be able to participate in appropriate early intervention services because they lack personal transportation to reach the program and the program cannot afford the cost of transportation for the child and/or parent(s). The incentive to participate in a child find process under these circumstances is impeded.

Strategies-Short-Term

1) Professionals need to take every opportunity to share recent research regarding the value of early intervention services for handicapped children and their families and the cost effectiveness of early intervention services for handicapped children.

2) The DD Grant which is designed to train social workers and other professionals in the identification and evaluation of young developmentally delayed children is a "Stop-gap" measure, but should be supported. Every effort should be made to see that this training continues after the DD Grant is concluded. County Welfare Department's staff development units should be encouraged to continue training regarding child find.

Long-Term Objectives and Strategies

1) Appropriate professionals need to be nurtured as advocates for the development of a comprehensive child find process in the State of Ohio including the identification, location, evaluation, and referral to the appropriate services for all developmentally delayed children, 0-4, in the State of Ohio. The implicit assumption in this process is that the appropriate comprehensive services exist to which the child may be referred.

   Agencies and organizations which are influential in establishing public policy should be informed of the current state of the art regarding child find, the effectiveness and efficiency of early intervention services, and nurtured as advocates for young handicapped children. Agencies such as the Coalition for the Education of the Handicapped, PAR, OARC, UCP, American Academy of Pediatrics, County Board of Mental Retardation and Developmental Disabilities Superintendents' Assocation, Children's Defense Fund, Ohio Citizen's Council, the Ohio Department of Health, the Ohio Department of Mental Retardation and Developmental Disabilities, the Ohio Department of Public Welfare, the Special Education Advisory Council, etc. need to promote the identification, location, evaluation, and provsion of comprehensive early intervention services for young developmentally delayed children in the State of Ohio.

Strategies

a) There should be a telephone and letter writing campaign initiated by parents and parent groups making state and federal legislators and other appropriate public officials aware of:

   (1) The current status of legislation regarding early childhood education.
   (2) The importance of early intervention for handicapped children.
   (3) The cost effectiveness of early intervention and research/study references for the same.

   They should be made aware of the obvious gap between mandated identification, location, and evaluation of all handicapped children below the age of 21 and the permissive provision of educational services for handicapped children below age 5 years. How does one deal with the situation "Yes, you have a handicapped child, but we don't have to provide anything beyond identification, location, and evaluation until he/she is 5 years old?" (This is a dilemma of the public school system.) County Boards of Mental

Retardation and Developmental Disabilities are mandated to provide education and habilitation from birth to death for persons with Mental Retardation and Developmental Disabilities.

b) Initiate cooperative effort with the "Ohio Coalition for the Education of Handicapped Children" and the Task Force for Early Childhood Education who are involved in a campaign similar to that mentioned in a above.

2) A coalition of interest groups needs to work cooperatively and aggressively toward a strong non-permissive mandate for identification, location, evaluation, and the provision of comprehensive services for all developmentally delayed children, 0-4, in the State of Ohio. This mandate needs to become a priority concern for the state legislature with the appropriate level of appropriations to meet this clear mandate.

Strategies

a) Inclusion of a line item for Early Childhood Special Education in the State budget.
b) Continued existence of the Child Development Committee and Early Intervention Task Force of the DD Council.

3) A single state agency needs to be designated by the legislature as the lead agency for coordination of early intervention services for all developmentally delayed children, 0-4, in the State of Ohio.

4) This lead agency needs to work in concert with all other state agencies to provide a continuum of comprehensive services including all of the 11 components adopted by the Early Intervention Task Force as necessary for a comprehensive local early intervention program.

Strategies

a) Magrab Presentation with early intervention task force regarding coordination of services for the 0-4 special needs child on state and local levels.
b) Selection of replication sites of the Magrab Plan.
c) Evaluation of results in terms of program comprehensiveness, effectiveness, and efficiency.

5) Universities need to evaluate their curricula for health and educational professionals to assure skill acquistion in the identification, location, evaluation, and provision of comprehensive early intervention services for handicapped children.

6) Mandated junior high and high school course work needs to include courses on human growth and development, to encourage early parental identification of development delays.

7) Comprehensive transportation systems including school districts, county boards, churches, social service agencies need to be developed on the county level.

8) Public awareness of the value of early intervention services for young developmentally delayed children needs to be increased.

Summary--Adequate documentation exists regarding the effectiveness and efficiency of early childhood special education. A coalition of State Departments under the leadership of a lead agency with a clear mandate to provide early childhood special education would ameliorate the gaps currently existing in the child find process in the State of Ohio.

INTERDISCIPLINARY DIAGNOSIS AND ASSESSMENT

Introduction--The definition used for this report is the one listed under "Ten critical components of an ideal, local comprehensive service system for young developmentally disabled children." However, appended to this report is a more comprehensive listing of disciplinary definitions, "Toward a Interdisciplinary Stance", which may better enable the reader to understand the variety and complexity of various groups in the diagnosis and assessment process.

Information from the compilation of the individual reports is contained under Mandate Across the State, Quality and Comprehensiveness of Service, Service Gaps, and Barriers to Service. Since no information was available under Strategies for Reducing Service Gaps, the committee has listed those that would appear to be reasonable and feasible.

1) Definition--a coordinated evaluation by a team of specialists from a variety of fields who assess the status and function of the child in all major developmental areas. Such an assessment team might include a psychologist, a physician, an educator, a social worker, a speech therapist, a physical therapist, and other professionals with training and experience relevant to both the child's and family's needs. (See attached for additional definition clarification.)

2) Mandate Across the State--Of the 13 agencies reporting, 11 agencies indicated that they operated under state or federal mandate to provide multi or interdisciplinary diagnosis and assessment while two agencies indicated that they were not under mandate to provide these services.

3) Quality and Comprehensiveness of Range of Service--The agencies rated this category on a 50 point scale in summary as follows:

Geographic availability*	35
Eligibility	48
Ranges of services	45
Quality of service	42

*Note that some agencies serve local populations and there was varience in the interpretation of this category.

4) Service Gaps--

   a) Lack of in-house professionals and staff for comprehensive evaluations.
   b) Lack of geographic uniformity in the availability of diagnostic and assessment services.
   c) County MR programs report that eligibility criteria jeopardizes diagnostic and assessment services to infants below two years and all high risk infants (i.e. child of MR/DD parents).
   d) The agencies made no reference to coordination across agencies.
   e) There was a noticeable lack of comment regarding the involvement of parents in this service.
   f) Lack of coordinated follow along for high risk infants.

5) Barriers to Service--

- a) Quality of service is often dependent in part on local or available professionals rather than in house staff.
- b) Lack of funds
- c) In some county programs, psychological evaluation and diagnosis is done by referral only.
- d) Complete interdisciplinary assessments are not always done promptly or on a timely basis and this delays programming.
- e) Lack of services that are recommended following assessment/diagnosis.
- f) Difficulty with follow through (i.e. Headstart to school program).
- g) Inadequate staff skills and opportunities for training.
- h) Splintering of service delivery

6) Strategies for Reducing Service Gaps--

a) Short term

- (1) Identification, delineation, and coordination of available diagnostic and assessment services including public and private resources.
- (2) Organize and coordinate the diagnostic services so that all geographic areas could be covered within a reasonable distance.
- (3) Develop interagency agreements for diagnosis and assessment.
- (4) In so far as possible, eliminate duplication of assessments
- (5) Explore the possibility of utilizing the neonatal logs to identify needs areas for diagnosis and assessment of high risk infants.
- (6) Coordinate programs of in-service education for professionals.
- (7) Identify needs for additional professionals in local areas.
    - (a) Identify availability of these professionals
    - (b) Coordinate/share services
- (8) Involve parents at all levels including policy making.

b) Long term

- (1) Influence legislation in terms of mandates for services and funds for the under four year old child.
- (2) From a state level coordinate public and private service delivery systems--including education and health services.
- (3) Form a Governor's Committee to explore and serve the needs of the under four year old.
- (4) Organize mobile units of diagnostic and assessment mini teams to serve the unserved areas who would also supplement local resources and serve as consultants to local communities.
- (5) Support training for personnel to work with the under four year old with emphasis on the Multi or Interdisciplinary approach
- (6) Develop a criteria for quarterly assurance.
- (7) Develop a program of ongoing program/services evaluation.

Summary--Diagnosis and assessment for the under four year old should be done by a interdisciplinary team. Although services for diagnosis and assessment appear to be fairly available, they do-not appear to be well coordinated. Barriers to these services--financial, legal, geographic should be removed. Efforts need to be expended toward developing criterion for quality services and evaluation of these services provided on an ongoing basis.

Each child should have diagnostic and assessment service available to him and programming services as needed. There are many agencies providing these services, however, there is little coordination. Implementation of any new diagnostic and assessment programming methodology should be pilot tested and evaluated within one area prior to state-wide dissemination.

It will only be when these services are geographically available to every child who needs them, the range of services adequate, the quality of service assured,and the financial base appropriate that we can say that we are meeting the needs of young children.

TOWARD A TRANSDISCIPLINARY STANCE

I.	Possessing a sound preparation and competency in one's own discipline.	Unidisciplinary
II.	Believing that (even alone) you and others in your discipline can make an important contribution to the habilitation of individuals at risk or with known neuromotor and neurosensory handicaps and/or mental retardation.	Intradisciplinary
III.	Recognizing that other disciplines also, have important contributions to make to the habilitation of individuals at risk, or with known neuromotor and neurosensory handicaps and/or mental retardation.	Multidisciplinary
IV.	Enunciating an activating philosophy that comprehensive services based on the habilitation needs of the individual must be made available to all who are handicapped.	
V.	Willing and able to work with other disciplines in the development of jointly planned programs for individuals and groups, and to assume responsibility for providing needed disciplinary services and treatment, as a part of the total habilitation program.	Interdisciplinary
VI.	Committing yourself to teaching and/or learning and working together with other providers of services across traditional disciplinary boundaries.	Transdisciplinary

INDIVIDUAL TREATMENT OR HABILITATION PLAN

1) Definition--A plan written with parental input and consent which usually specifies strengths and weaknesses of the child, present level of functioning, specific long and short range objectives for programming, and provides for periodic reevaluation and revision. The plan may be called an Individual Treatment, Habilitation, Education, or Service, or Program Plan depending on the sponsoring agency.

Mandates Across the State--The mandate for IEP's originates from public law 94-142. IEP development is the responsibility of the local education agency.

Section 3323.07 of the Ohio Revised Code states: Special education programs authorized

The state board of education shall authorize the establishment and maintenance of programs for the education of all handicapped children of compulsory school age, and may authorize such programs for handicapped children who are not of compulsory school age. The state board shall require the boards of education of school districts, shall authorize the department of mental health and the department of mental retardation and developmental disabilities, and may authorize any other educational agency, to establish and maintain such special educational programs in accordance with standards adopted by the state board of education.

The Ohio Revised Code defines IEP's as follows: "Individualized education program" means a written statement for each handicapped child designed to meet the unique needs of a handicapped child, which statement shall include:. . . .

The guidelines for IEP's are addressed in the Ohio Department of Education, Rules For The Education Of Handicapped Children, which states:

> Amended Sub. S.B. No. 160 states: Sec. 5126.05. "SUBJECT to the rules ESTABLISHED BY the director of the department of mental retardation and developmental disabilities PURSUANT TO CHAPTER 119 OF THE REVISED CODE, THE COUNTY BOARD OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES shall:
>
> (G) REQUIRE INDIVIDUAL, HABILITATION PLANS FOR CLIENTS AND ELIGIBLE UNSERVED CLIENTS;"

Each school district shall develop and implement written procedures which require that the decision to place a child into a special education program is made by a group of persons. Such persons must be knowledgeable about the child, the meaning of the evaluation data, and the placement options.

The Head Start Program has a federal mandate to provide an Individual Service Plan for each handicapped child and the process must be ongoing.

The Bureau of Crippled Children is mandated by the state to authorize treatment and due to that mandate provides an Individual Treatment Plan for each child.

The local agencies that are affected by the mandates are:

1) All public school districts
2) All agencies administered by the Department of Mental Retardation and Developmental Disabilities
3) DD Council Grantee--A Mother's Friend
4) Nisonger Center
5) Head Start
6) Crippled Children

Quality of Comprehensiveness and Range of Service--The quality of IEP's varies greatly across the state. Proper procedures are not always followed, implementors may not be knowledgeable of the evaluation data and as a rule the rural areas may not provide many placement options. A needed service may not be mentioned due to the fact that the particular service is not presently being provided.

Some school districts follow the guidelines regarding IEP activities to the letter while other programs do not. All school districts do provide IEP's for all children in special education programs though there is variation in execution, the involvement of the parent and the individualization which consequently greatly varies the overall quality.

Service Gaps--

1) Many times only the "letter of the law" is adhered to not the "spirit of the law". When this happens, the IEP does not serve its intentional purpose.
2) Degree of Generalities--IEP's can be written in such general terms that the concept of individualization is eroded.
3) The professional who writes the IEP is not necessarily the person who will be carrying out the IEP and due to differing philosophies and due to human nature this may cause significant problems in regards to adherence.
4) Parents are not always involved in the planning of an IEP.
5) Needed services are not mentioned because the service is not presently being provided.
6) A good working relationship does not always exist between various educational agencies.

Barriers to Service--

1) A needed service not provided because it is not presently an existing service.
2) Parents not having transportation, or being unable to take time off from work, or not having child care services.
3) Parents may not be well informed or understand the terminology and may not be included in the planning of an IEP.
4) Professionals not always well trained in writing and/or implementing the IEP.
5) Professionals don't always agree on the desired IEP outcome.
6) The assessment information used for IEP may not be appropriate or comprehensive as needed.

7) The IEP many times is too vague and the concept of individualization is erroded.

Strategies for Reducing Service Gaps--

a) Short term

(1) Including parents in the planning of an IEP on the local level as much as possible.
(2) Professionals need to work as an interdisciplinary team to develop an IEP that is definitely child centered and individualized.

b) Long term

(1) Professionals need to receive more training in the area of individualized assessment so that IEP's will be most meaningful and child centered.
(2) Adequate funding needs to be provided so that all handicapped children are appropriately placed in the least restrictive educational placement.
(3) The development of quality curriculum materials which address the format of IEP's.
(4) A good working relationship needs to be established between all educational agencies.
(5) Parents should be informed and trained to become advocates for their children.
(6) IEP's need to be done in the "spirit of the law".

COMPREHENSIVE SERVICES COMPONENT

1) Definition--The Early Intervention Task Force adopted the following definition of comprehensive services: "A full range of programmatic services designed to meet the individual client's needs provided through coordination or integration of services among multiple service providers. Such services would include: mental health education, medical, transportation, social/recreational, legal and/or advocacy, among others."

   This definition should be reviewed from two distinct, but interrelated points of reference: 1) type and range of services; and 2) coordination or integration of multiple services across agencies. The mission of the Early Intervention Task Force is to identify the "state of the art" in each of these areas, evaluate current services in Ohio, and prioritize strategies to remediate Ohio's services to handicapped infants and young children.

2) Type and Range of Services--There is a vast amount of literature evaluating models of early intervention. The most commonly shared dimensions of comprehensive range of services has been outlined by the report compiled by the Frank Porter Graham Child Development Center and adopted by this task force. In addition the literature on early intervention and it's effects on developmental outcome reiterate the following as critical issues for any service models:

   a) Developmental outcome is affected by the interrelationship of the child's medical, educational, and social/environmental status. If one aspect of this complex structure is disturbed the intervention program is affected.
   b) Family participation is essential for effective evaluation and intervention. The parent-child interaction, as well as physical environment, have a positive effect on developmental outcome.
   c) Due to the spiral effects stated above, age of intervention also has a dramatic effect on developmental outcome.

3) Interagency Collaboration--The service needs of handicapped children and their families are complex, inevitably involving several disciplines with varying models of service delivery with the educational and medical models to name just two. Several authors point out that in order to provide comprehensive service, as defined by the current literature, we must begin to look at collaboration between generic agencies. A number of models exist where community interagency teams have established collaborative systems for client service. Elder and Magrab (1980) have designed such a system for coordinating services to handicapped children. Literature reviews of such systems repeatedly point out that the following issues and concerns are generally present.

   a) Collaborative systems must be focused on improved client service and not upon the system itself.
   b) Responsibility for establishing coordinated services rest in several spheres.

      (1) At the family level--to the extent possible, the family should actively participate as the "natural" casemanager.
      (2) At the community level--agencies from both private and public

sectors, must develop the means to coordinate efforts among direct service workers for specific case management, and administratively to facilitate policy management goals that nurture linkage.

(3) At the state level government which can influence interagency collaboration by establishing such activity as a high administrative priority.

4) Mandate--In the State of Ohio the mandate for comprehensive services is primarily the responsibility of the Department of Education and the Department of Mental Retardation and Developmental Disabilities.

The mandates governing these departments states:

a) Department of Education--State plan "to ensure that a free and appropriate public education is available to all handicapped children age 3 through 18." Exception: The requirement does not apply to a state with respect to handicapped children age 3, 4, 5, 18, 19, 20, 21 to the extent that the requirement would be inconsistent with state law. (3323.07)

"A child between 6 and 18 years is of compulsory school age." (3321.01)

"A comprehensive program for handicapped children shall consist of instructional services at the elementary and secondary levels and may include services with the preschool level." (3301-51-13A.5)

b) Department of Mental Retardation and Developmental Disabilities--"The Early Childhood Program consists of instructional services that provide a comprehensive education and habilitation program for a mentally retarded and developmentally disabled child whose chronological age is 6 years and below." (MHr-1-05)

Both the child and his or her family are eligible for service. (MHr-1-05)

Early Childhood Education Programs shall be highly specialized, Program content shall be based on individual objectives as indicated by assessment data. Early Childhood Programs shall include, but not be limited to, the development of increased skills in each of the following areas: 1) Communication, 2) Caring for Self, 3) Physical Development, 4) Social Competence, and 5) Parent Education.

There are several federal programs which provide assistance to states and localities who choose to serve the preschool age handicapped population. Some of these programs which are in operation in Ohio are listed below along with their purpose:

a) Head Start (Title V, Community Services Act)--"To provide comprehensive health, educational, nutritional, social and other services primarily to preschool economically disadvantaged children and their families. No less than 10% of total number enrolled in Headstart shall be available to handicapped children." 106

b) Maternal and Child Health (Block grant)--"To provide health care services for the maternal-child population primarily armed at preventative health care."

c) Supplemental Security Income: Disabled Children Program (Title XVI, Social Security Act)--"To develop a plan of action to serve the medical, social, educational, habilitative-therapeutic needs of children receiving SSI. This accomplished through advocacy, case coordination and referral."

d) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Amendment to Title XIX, Social Security Act)--"To improve the health status of poor/needy children (ages 0-21) nationwide through early detection and treatment of disease and disabilities. To maintain a system of continuing health care which includes outreach, screening, treatment, scheduling and transportation."

5) Quality of Comprehensive Services--The quality and range of comprehensive services vary across program mandates and between units across the state. The rural communities being the most effected. Interagency coordination also varies across the state. The problem is especially complex in urban areas where the client population is large and the number of potential service agencies is numerous.

6) Service Gaps--

a) Range of Services--Although many mandates specify or imply comprehensive service, the actual availability of service is not consistent for all handicapped children throughout the State of Ohio.

(1) The literature support is very strong, concerning active parent participation and developmental outcome, yet few programs facilitate comprehensive service to the parent(s)-child dyad. Fewer still involve other members of the family.

(2) Access to a variety of support services is often limited, both in terms of number of services and frequency of contact. Both issues are reflected on the individual child's IEP/IHP commitment of services.

(3) Transportation services are often limited to geographic area or restricted by age therefore effectively eliminating service to many clients.

(4) The ability to integrate handicapped with non-handicapped children is limited largely to Headstart programs and dual programming with private centers. This situation limits the child's preparation for the least restrictive placement at school age.

(5) Age restrictions and type of handicap(s) mandated often prevent service to children in need of early intervention. "At risk" children and pregnant women are two such categories that are underserved in the State of Ohio.

b) Coordination and Integration of Services--

(1) Case management services are inconsistently available. The variance is effected by program mandate and caseload size. Medical based programs and social agencies provide the most extensive case management. Coordination between medical, social, and educational agencies is situationally dependent.

(2) Agencies often duplicate service efforts, such as child find, referral services and assessment of services needed.
(3) Agencies are often unaware of the complete range of services available for the 0-4 year age group in a given community.
(4) Interagency collaboration is often limited to specific direct service workers sharing a mutual case. Policy management and administrative linkages have not been actively developed at the state or agency level.

7) Barriers to Service--

a) There is no federal policy that provides an assurance of comprehensive developmental services to all handicapped children 0-4 year and their families. P.L. 94-142 provides limited assurance of minimal service provided this is consistent with state rules. Ohio's law is permissive, rather than mandated with regard to services for the 0-4 year population. Other federal programs providing assistance for services to preschool handicapped children include Head Start, MCH, SSI, EPSDT.
b) The existing mandates are inconsistent with respect to definitions of comprehensive services, handicapping conditions requiring service and appropriate age for intervention.
c) Services to children 0-4 year and their families are fragmented across several service providers. Interagency collaboration is largely limited to case management between direct service workers. Policy management and administrative linkages are lacking.
d) A consensus of opinion does not exist within the state as to the most appropriate primary service provider, for example, State Department of Education responsibility, Human Services responsibility, or a combination of both.
e) Funding levels and lack of funding parity with the school age service limit agencies' ability to expand service in areas that have been well documented as having a positive developmental outcome. Specifically, service is limited in the areas of case management, parent involvement, transportation, and other support services.

8) Objectives and Strategies for Reducing Service Gaps--

a) Short term strategies

(1) The Early Intervention Task Force should review the issues related to population definitions and scope of services and recommend consensus definitions to the DD Council and other sources where appropriate.
(2) Based upon the current status of multiple service providers in Ohio, the Early Intervention Task Force should review the issues and recommend a strategy to faciliate interagency collaboration.

b) Long term objectives and strategies

(1) Ohio should move from permissive to mandated services to children 0-4 year and their families. These services should be comprehensive in nature with accompaning rules and regulations to operationalize the concept. Care should be taken to include all handicapping conditions that would benefit from early intervention. The rules

and regulations should also facilitate the implementation of concepts that have been repeatedly shown to be positive for development outcome; for example, parent involvement and integration of non-handicapped children.

Strategy--Implementation of the first objective to be presented the the Child Development Committee.

(2) Interagency collaboration needs to be established as a state level directive with subsequent legislative support. Implementation plans for interagency collaboration should be developed at the local community level.

Strategy--Implementation of Magrab model at three geographic sites.

(3) Early intervention programs should receive parity funding with the school age non-handicapped population. The additional funding is needed to expand support services such as case management, parent involvement, transportation, and increased speciality staff.

Strategy--Recommended as a priority to the legislative coalition.

9) Summary--From the literature on early intervention and analysis of current policy, the following conclusions can be drawn:

a) Early intervention has been documented as beneficial to society.
b) Current federal and state policies do not assure the availability of comprehensive early intervention services to all handicapped children 0-4 and their families.
c) Rules and regulations of specific programs do not effectively facilitate implementation of comprehensive service as it is defined in the literature on early intervention.
d) State government needs to take an active role defining, legislating and facilitating community interagency collaboration.

CONSUMER INVOLVEMENT

Introduction--Consumer/family involvement is a vital part of any program for a child with a disability because of the intimate involvement of the family with the child in all phases of his/her life.

1) Definition--Consumer involvement with respect to early intervention programs can be defined as "opportunities for active involvement of parents in all phases of program operation including both the design and evaluation of programs for their individual child and significant input into overall program design and evaluation."

2) Mandate--The obvious benefits of consumer involvement made the passage of laws to mandate it inevitable. Thus laws such as P.L. 94-142 require consumer involvement in the educational process. Thus, programs recognized as educational, such as County Board of MR/DD, preschools, Head Start programs, and disabled children programs are mandated to include consumers/families in their assessment, planning, and programming.

3) Quality and Comprehensiveness of Range of Services--The assessment of the quality and comprehensiveness of services must necessarily be subjective and depends greatly on the individuals involved. Therefore, information, to be accurate, must be obtained individually with each provider and consumer. Appropriate follow-up must also occur.

4) Service Gaps--It is difficult to ascertain where gaps lie without closely monitoring programs. It is safe to assume that most programs have gaps of varying degrees in services because of the many barriers which exist.

5) Barriers to Service--

   a) Time constraints of staff. Many times staff members would like to involve parents and families but have little or no extra time to confer and advise the family on how they could become involved.
   b) The attitude of staff. Staff members may consciously or unconsciously blame the parents for the problem. The staff may not be aware of the proven benefits of parent/family involvement: "Cooperative efforts between home and school can accelerate the rate of learning. Fredericks, Baldwin, and Grove (1976) report that adding meaningful parent involvement to the school program will almost double the rate of acquisition of skills."
   c) Attitude of parents. Many parents are intimidated by the "Professionalism" of the staff. They are intimidated by being outnumbered at parent-staff conferences. They are intimidated by the traditional "professional to lay person" role.
   d) Attitude of parents toward their own capabilities and responsibilities. Many parents do not understand the very necessary role they can and should play in the life of their child with a handicap.
   e) Attitude of the staff toward their role in the life of the child with a handicap and his family. Many staff do not feel that their responsibilities should extend beyond the classroom because every minute of their day is needed in the classroom.

f) Lack of coordination efforts by supervisors. Many supervisors do not arrange for time for their staff during the school day to work with families or to attend much needed in-services to learn more about how to involve families.
g) Lack of training of staff and parents/families in effective ways of working with each other.
h) Lack of professional involvement with parents/families early in the life of the child with a disability.
i) Make-up of group involved in staff-parent conferences. Many times parents are greatly outnumbered by professionals and little is done to alleviate this situation.
j) Use of "professional-ese" at conferences. This usually loses parents who felt at a disadvantage anyway and who feel rather embarassed to stop the flow of conversation to ask for an explanation of a term everyone else at the table seems to understand.
k) Lack of information to parents prior to a conference concerning what is to be covered. Many times a parent is the only one at the conference who does not know what is to be discussed.
l) Seating arrangement of participants in a conference. Many times the seating arrangement reflects an "our side-your side" attitude.
m) Time constraints placed on parents by jobs or other "non-handicapped" children in the home.
n) Lack of transporation.
o) Lack of babysitters.

Strategies--

a) College level courses for training professionals to learn effective ways of working with parents/families of persons with handicaps, and to be sensitive to their needs.
b) In-services for parents and professionals to learn to work with each other more effectively.
c) Training for parents to learn how to effectively evaluate the appropriateness of their child's program and how to work for changes.
d) Provide substitutes and time for teachers during the day to work with parents and to attend in-services.
e) Training parents to become their child's case manager.
f) Parent to parent training.
g) Neonatal log to find families early.
h) Contact parents early. Don't wait for them to find the services.
i) Clearing house for information about case management available to parents to access.
j) Exclude use of acronym, abbreviations, and professional terms at parent-staff conferences.
k) Encourage parents to observe the classroom before the conference.
l) Encourage parents to be involved in the classroom on a regular basis.
m) Send to parents/family a summary of ideas to be covered at the conference and encourage them to add to it points they want covered and questions they may have.
n) Encourage parents to bring a friend, advocate, and/or professional who knows the child to the conference.
o) Arrange the seating of the conference so the parent feels a part of the group, then allow the parent plenty of chances for input.

p) Assume that the absent parents are not disinterested but rather intimidated or unable to attend, and seek to alleviate the situation.

q) Alternate meeting place for conference (parents home to school to home, etc.).

r) Hire a parent consultant to arrange and coordinate the strategies for the elimination of barriers.

FOLLOW ALONG

1) Definition--A formal mechanism to ensure that the child actually receives needed additional services provided outside the scope of an individual program. These services may be provided either concurrently with ongoing services or through referral or transfer to another agency at the time of termination of primary service responsibility.

2) Mandates--The following agencies represented on the Early Intervention Task Force indicated that they had a mandate to provide follow along services: Head Start, Bureau of Crippled Children's Services, SSI/DCP, Department of Mental Retardation and Developmental Disabilities (Adult Program), and Mother's Friend.

3) Quality, Comprehensiveness and Range of Services--

   a) EPSDT--The follow along component in EPSDT is comprehensive. Follow along assistance links the child/family with the service provider for the initial appointment and any community linkages that may be appropriate as a result of the initial screening. Follow along also occurs if the parent fails to keep the first appointment. As part of the periodic follow along process, the family is contacted when the child is 4, 7, 11, and 16 years of age as well as on an annual basis in the State of Ohio. Newborn Screening links the child within four to six weeks of birth to a medical provider for initial screening. Consequently, the follow along component is initiated very early in the child's life.
   b) SSI--Disabled Children's Program--This program currently is mandated to provide rehabilitation services to children receiving SSI. All former specific mandates prior to the block grant funding mechanism are nonexistant, but the program struggles to perform as it did previously. Children remain active in this program for a short period of time. Parents are contacted; the assessment is done and the linkage is made to the necessary services. Referrals may be medical, educational, advocacy, or social welfare in nature
   c) Bureau of Crippled Children's Services: Follow along to ascertain that authorized services are being accessed is done by ten field representatives. Services are provided by approved local physicans. Assistance usually occurs once annually.
   d) Head Start--When a child is first identified and evaluated, appropriate professionals meet to develop an Individual Service Plan (ISP). At least twice a year all outside agency involvement and outcomes are studied when the child's progress is reviewed.

      This outside involvement may include Children's Mental Health, the local public school, EPSDT, etc. Specific program components have various follow along time lines, e.g., the child's immunizations are to occur within two weeks of enrollment. If they do not, Head Start takes the parent and child to the Health Department for the immunizations.

      It is infrequent that the Head Start teacher and the future kindergarten teacher from the public schools exchange information regarding the child's needs. After the Head Start experience, the parent has no case manager to provide continued follow along services. While the child is in the program the lack of follow along services in the summer months may cause regression in the child's progress. Parents may lack transportation to meet necessary appointments. Some agencies do not share information regarding the child, and may not be as open to understanding parents' difficulties in meeting appointments. Head Start may have indicated on the child's ISP that an outside service would be delivered on a regular basis, but this doesn't happen. Head Start has no authority to cause other agencies to do what they have agreed to do.

Department of Mental Retardation and Developmental Disabilities and County Boards of Mental Retardation and Developmental Disabilities: Follow along is not a mandated service for children, 0-4. Informal community contacts may be made on behalf of the child by a concerned teacher or staff person.

Some follow along services are provided by Supportive Home Services staff in County Boards of Mental Retardation and Developmental Disabilities. These services might include taking children to medical appointments, evaluations, visitations, etc. Some children are followed into a Head Start program or day care program or public school program to help facilitate the transition period. The Supportive Home Services Rule specifically includes "linking services between families and communities" as an acceptable reimburseable activity for this program. Also mentioned in this rule is "contacting community and agency persons to identify persons needing referral to a program.

e) Mother's Friend--The Mother's Friend Project funded by the DD Council has follow along as one of the required activities in its grant. When a child is enrolled in this program, the appropriate regular service provider is contacted and an appointment made for assessment. Mother's Friend staff persons accompany the family and may provide transportation services. Staff from the Mother's Friend Project are part of the team in the development of the individualized habilitation plan for the child. Mother's Friend staff and the referral agency coordinate program implementation. The project has access to a pediatrician who helps Mother's Friend staff ascertain when a medical referral is appropriate. The project supports the parent in making the medical appointment and providing transportation, if needed. Social service referrals are also initiated by this staff.

4) Service Gaps--The quantity and quality of the follow along component in many comprehensive early intervention programs is dependent upon the commitment and competency of the individual staff members. This may even be true of programs with clear, strong mandates to do follow along. In most cases the follow along service is only available while the child is eligible for and receiving services from a specific program. Age and eligibility constraints cause gaps in service, e.g., the Bureau of Crippled Children's Services end when a child is 16.

5) Barriers to Services--Since the mandate is frequently weak in a program, limited staff and resources cause the follow along component to be a low priority in service delivery. "Turfism" and confidentiality issues may prevent open sharing of information regarding a child's needs. Parental responsibility in managing the appropriate follow along services is not always appropriately encouraged and facilitated. In the Head Start situation, public school kindergarten teachers, are not usually responsive

to evening staffings on future students. Professional attitudes regarding the parents may be negative and needed follow along services from other agencies may cease when parents sense a lack of respect, support, and nurturing from the professional in the outside agency.

Department of Education--Since the Department of Education has no mandate to provide comprehensive early intervention service to the child with special needs, 0-4, follow along after identification, location, and evaluation is a major gap.

Hearing impaired children may receive in-home services through a federally funded, state administered program as young as diagnosed. There are, however, only two staff persons working in this program state-wide. The families of impaired children may receive in-home consultation and counselling from the Bureau of Services for Visually Handicapped Children.

6) Strategies--With the dependency of this component upon the commitment and competency of the individual staff person, it would seem that the follow along component generally needs to be formalized. Greater emphasis needs to be placed on interagency task forces to promote informal exchange regarding interagency cooperation. The concept of transition programming needs to be encouraged so that the benefits of the new program flow to the child quicker and with less trauma for the child.

Eligibility for follow along services from a specific agency should be extended, when appropriate, beyond eligibility for program services.

A study would be in order to graph what age child with what kind of a delay/disability is eligible for what components of the local comprehensive service delivery system.

All agencies need to improve efforts in training staff to train parents to become their child's own case manager. Parents can be the most effective implementors of follow along services for their child.

EVIDENCE OF PROGRAM EFFECTIVENESS

Introduction--The Frank Porter Graham Child Development Center in North Carolina has identified ten critical components of early intervention services. One of these components is the provision of evidence of program effectiveness. A quality early intervention program should be able to deomonstrate that it's services are effective in some predetermined manner. This section provides an overview of the current status of early intervention services with regard to the demonstration of program effectiveness.

1) Definition--The Frank Porter Graham Child Development Center defines evidence of program effectiveness as:

> "some systematic evidence in addition to monitoring of individual child progress which shows that the overall program is effective in facilitating the progress of groups of children." (underlines added)

In essence, the definition indicates that it is not sufficient to merely monitor the progress of individual children. In addition, there should be some evidence that groups of children are benefitting from the program. This can be accomplished in several ways, depending upon the particular research issue in question.

In fact, it is useful to perceive the component of program effectiveness as being on a continuum ranging from no monitoring of individual children's progress on the one extreme to a comprehensive analysis of which programmatic features are most helpful for which groups of children on the other extreme. This may be visually depicted as in the following diagram:

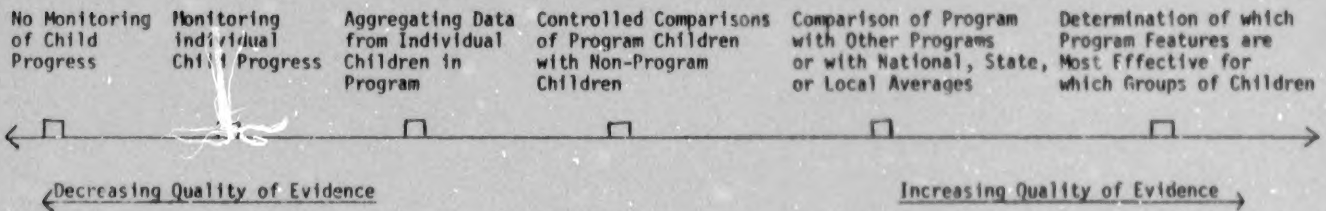
No Monitoring of Child Progress
Monitoring individual Child Progress
Aggregating Data from Individual Children in Program
Controlled Comparisons of Program Children with Non-Program Children
Comparison of Program with Other Programs or with National, State, or Local Averages
Determination of which Program Features are Most Effective for which Groups of Children
Decreasing Quality of Evidence
Increasing Quality of Evidence

Figure 1. Evidence of Program Effectiveness

As the specific strategies progress from left to right, the quality of evidence improves. Those strategies towards the right provide relatively more interpretable and more conclusive evidence regarding program effectiveness than do those on the left. A brief description of each strategy follows:

a) No Monitoring of Child Progress--This strategy is really not providing any evidence of program effectiveness. In this case, no systematic records of children's progress are maintained. No claims of program effectiveness can be made.

b) Monitoring of Individual Child Progress--A program employing this technique maintains records for each individual child in the program. These records contain data which monitors the progress of each child. While someone reviewing these records could make judgements concerning the progress of individual children, he/she could not systematically judge whether the program as a whole is effective or not.

c) Aggregating Data from Individual Children--In this case, the progress records of each child are in some way aggregated to generate data on the overall effectiveness of the program. Thus, for example, it may be determined that 70% of the children in the program have made significant developmental strides in the last year. Such a statistic documents that most children are making progress, but does not allow one to infer that the program itself has been responsible for the change. Factors other than the program (improved parental care, normal developmental growth) may have been the prime cause.

d) Controlled Comparisons of Program Children with Non-Program Children--One method of more precisely determining the causes of child progress is to systematically compare the progress of children in the program with those not in the program. If, for example, 80% of a group of children in the program with retardation make significant IQ gains, while only 40% of a similar group not participating in the program make similar gains, one has convincing evidence that some characteristic of the program is responsible for the differential levels of progress for the two groups. In a similar fashion, one might compare the progress of program children with another different group of children either in or not in the program (e.g., gains in IQ in the group with retardation could be compared with a group of normal children).

e) Comparison of Program with Other Programs--Once one has provided evidence of the effectiveness of a particular program, one can gain even more information by comparing the effectiveness of the program with other programs providing similar services to a similar population. If Program A, employing home visits yields substantial progress in 80% of the targeted children, while Program B, using the same methods with the same population, yields substantial progress in only 40% of the targeted children, one knows that some feature of Program A makes it particularly effective. At this point, however, one does not know which features these are.

f) Determination of Program Features Which are Most Effective--At this final level, systematic evidence is gathered to determine which features of the program are most successful with which children. For example, from such an analysis, one might conclude that home based services are particularly effective with mildly retarded preschoolers, while classes seem to be more useful with a differing group of children. The methods employed to be able to make such inferences are varied. One might, for example, develop two identical programs with one critical program component differing between the two and then compare their effectiveness. If home based services and parenting classes alone, then one might conclude that home based services do not in and of themselves, add significantly to treatment efficacy.

2) Mandates for Measuring Program Effectiveness--This section presents the legal mandates for measuring program effectiveness. It appears that there are at least three types of mandates:

a) Mandates to measure program effectiveness based on individual child progress and/or progress of groups of children.
b) Mandates to monitor the number of children served as a measure of effectively reaching the target populations.
c) Mandates to do various kinds of idiosyncratic documentation.

Below are descriptions of the mandates.

a) Mandates to Monitor Individual Child Progress--There exist a variety of legal mandates for the measurement of program effectiveness which impact upon Ohio early intervention service providers. These mandates, to be described below, further require the monitoring the local programs' compliance with the mandate by a state or regional organization.

Following is a summary of the mandates of three bodies which have clear mandates to measure program effectiveness.

(1) School Districts--Local school districts are mandated by P.L. 94-142 to have Individual Education Plans (IEPs) for each child in a special education program. The IEPs are to state the child's current level of functioning and to plan long and short term goals for improvement of functioning and activities to meet those goals. These IEPs are to be reviewed and updated at least annually. The Ohio Department of Education--Division of Special Education is mandated by A.H.B. 455 to monitor the local district's compliance with this mandate. Further, the state standards require that each special education program annually summarize: 1) the developmental areas in which the students have progressed the most; and 2) the areas of need which are most evident along with plans for meeting that need the following year.

(2) County Programs for MR/DD--County programs are also mandated by P.L. 94-142 to have an IEP developed by the LEA for each child. The Ohio Department of MR/DD is mandated by the Ohio Revised Code, A.H.B. 455 and Chapter 1 of 89-313 to monitor the local programs' compliance with this mandate. In many cases, the development of this program plan does not include the participation of personnel from the local school district and, in fact, meets the state mandate of an IEP for each person enrolled in a County Board of Mental Retardation/Developmental Disabilities (ORC 5126.05). The IHP is based on a mandated comprehensive evaluation. Progress data must be recorded every 90 days.

(3) Head Start--Local Head Start programs are mandated by Title V of the Community Services Act to measure the compliance of their program with a set of performance standards in areas of health, education, parent involvement, and administration. The use of a developmental test to measure children's performance is mandated as are individual plans for the children. The regional Head Start offices, also mandated by Title V of CSA, conduct annual surveys of the local programs. This survey includes an examination of individual child folders, and thus the individual plans.

3) Mandates to Monitor Numbers of Children Served--Some groups have mandates to record the numbers of children served and to make program reports. These include Early and Periodic Screening, Diagnosis, and Treatment, Supplemental Security Income-Disabled Children's Program, and Ohio Department of Health--Maternal and Child Health programs. In addition to recording numbers served, some categorical programs under Maternal and Child Health have requirements for measurement of program effectiveness.

4) Mandates for Documentation--Some programs have requirements for documentation of program effectiveness which originate from the local sponsoring agency or foundation. This could range from documentation of face to face contacts as an indicator of program effectiveness to monthly reports to a full-fledged comparison of children receiving the program with similar children not receiving the program. A Mother's Friend project is an example of this--the major funding source (ODMR/DD) mandates and the local sponsoring agency's (Southwest Community Health Centers) requirements effect the measurement of program effectiveness done by this project.

In summary, some programs providing early intervention services in Ohio are funded by a single source and are functioning under only one set of mandates for measuring program effectiveness. Other programs may have multiple funding sources and thus would be measuring program effectiveness based on the range of mandates originating from these funding sources. Still other programs have mandates from both funding sources and local sponsoring agencies which will determine the scope of their measurement of program effectiveness.

5) Quality of Service--When evaluating the quality of the evidence of program effectiveness, it is important to keep in mind that it is the methodology of gathering the evidence that is important and not the actual evidence itself. In other words, our interest in this section is to explore the range of methods employed to evaluate early intervention programs in Ohio. Although ultimately critical, we are not as concerned here with the results of the program evaluation.

It is important to distinguish between two distinct levels of evaluation. The first is concerned with the data collection actually conducted by the local service provider, while the second is concerned with evaluations conducted by bodies responsible for ensuring that the local programs meet their mandates. For example, the county boards of MR/DD are responsible for collecting data on individual children, while the Ohio Department of MR/DD is responsible for monitoring the local county programs. Because the actual evidence of program effectiveness is derived from the first level, our focus for the most part will be with those activities at the local level.

With this in mind, the methods of collecting data relevant to program effectiveness vary considerably across the state. In addition, the quality of the evaluations also vary a great deal. This variance is the result of a number of factors, including the nature of the services provided, the amount of resources available for program evaluation, the quality of the leadership advocating evaluation, the numbers of children served, and any legal mandates the program might have.

While there is considerable variance, there are trends which are common among many programs. Many programs, particularly those which are publicly funded, are mandated to and do monitor the progress of individual children. The Ohio Departments of Education and Mental Retardation and Developmental Disabilities and Head Start require that local school districts, county developmental disability programs and Head Start grantees develop individualized intervention plans for each child in the program. These plans, called Individual Habilitation Plans (IHP) by the county board of mental retardation and developmental disabilities programs and Individualized Education Programs (IEP)(DOE), are to be monitored on a regular basis. Thus, from such data, one could assess whether the program was effective for a number of individual children. However, because this data is not aggregated, one could not judge in a systematic way whether or not the program was effective for the group as a whole. Because this is not possible, one cannot compare the progress of children in the program with that of children not in the program.

There are several groups of programs that do not monitor the progress of individual children. This is primarily due to the large numbers of children served and to the fact that treatments in these programs are fairly standardized across children and do not require individual treatment plans. These programs, which include Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and the Bureau of Maternal and Child Health of the Ohio Department of Health, provide primary health care for children. While not monitoring individual children, they do count the number of children they serve. They also utilize social indicator indices to assess the relative effectiveness of their services. Thus, by comparing improvements in Ohio's neonatal mortality rate with national averages of improvement, the Bureau is indirectly evaluating the effectiveness of the Maternal and Child Health care services provided in Ohio. Similarly, by comparing prevalence and incidence rates of certain handicapping conditions among Ohio children served by the program with national rates or by comparing counties within Ohio, EPSDT is evaluating the quality of its services.

There are some early intervention programs across the state which are conducting more sophisticated evaluations of program effectiveness. Several special projects funded by the Ohio Department of Mental Retardation and Developmental Disabilities conduct such evaluations. For example, A Mother's Friend, the early identification and intervention project in Columbus, utilizes an extensive evaluation strategy. Data is collected on a pre and post-test basis from both children in the program and children not in the program. Thus, some conclusions relating to the effectiveness of the program can be made. Pre and post-test data is also collected from program mothers to determine whether such factors as self-esteem and social support are related to child developmental progress.

It is difficult to assess the quality of evaluation in privately funded early intervention programs. Since they are not required by law to evaluate the effectiveness of their services, it is likely that the great majority do not systematically assess the progress of groups of children. While many may count the number of children served and monitor their progress, they usually do not aggregate this data and/or make comparisons with children from outside the program.

6) Service Gaps--Considerable effort is currently being made to evaluate the progress of individual children in many early intervention programs. It is in many ways encouraging to know that programs monitor the progress of their clients as carefully as they do. This is certainly a necessary precondition for the continued growth and development of the children involved. However, there is far less effort being made to systematically evaluate the quality of services.

It would be helpful if programs could evaluate their effectiveness in more systematic ways. On the one hand, the evaluation process is designed to continually provide feedback which helps the program provide higher quality and more efficient services. One might determine, for example, that home based services are particularly effective with a particular group of children while center based services to be more effective with a different group. This information impacts upon service delivery, making it more effective and more efficient. In these times of uncertain and dwindling resources for human services, effectiveness and efficiency are critical.

On the other hand, it is important that early intervention advocates are able to demonstrate that their services are indeed effective. A sound empirically based body of evidence should establish that: 1) early intervention is effective in preventing or ameliorating the effects of developmental disabilities and other handicapping condtions; and 2) early intervention services are cost effective in terms of saving money that would have been spent on the child later in his/her life. The ability to demonstrate either or both of these two consequences of early intervention would be extremely valuable for those trying to secure funds for these services.

Current evaluation strategies limit the extent to which these claims can be made. There are relatively few programs which compare the progress of program children with a comparison group of children not in the program. In addition, even fewer evaluate the individual features of the program in terms of when and for which children they are most effective.

7) Barriers to Service--There are several reasons why early intervention programs across the state are not more systematically evaluating their effectiveness. These include a lack of financial resources, a lack of commitment to program evaluation, and a lack of research expertise on the part of administrators and planners.

   a) Lack of Financial Resources--Current funding for early intervention in Ohio is so limited that perhaps quite appropriately, the provision of direct service is given a higher priority than is program evaluation. When there is evidence that many children are currently underserved, it is difficult to justify allocating funds for evaluation pruposes which otherwise would be utilized to serve children. Nevertheless, the quality of service will not significantly improve until both direct service and evaluation activities are sufficiently funded.

   b) Lack of Commitment to Program Evaluation--Individuals skilled in and committed to program evaluation often confront resistance from administrators, service providers, and consumers in their attempts to evaluate human service programs. On the one hand, many have the belief that service delivery is considerably more important than evaluation. Because successful program evaluation is relatively rare, many professionals have not witnessed the benefits of evaluation enough to understand its importance.

On the other hand, evaluation activities are often perceived as merely additional busy work and paperwork that add a significant amount of stress to the job. The rewards and benefits derived from program evaluation are not as immediately visible as are those from direct service to children. Because of this, the importance of the evaluation process must be continually stressed.

c) Lack of Research Skills--Perhaps unfortunately, traditional training programs have clearly distinguished between direct service and research, placing a greater emphasis on service delivery. Consequently, administrators and service providers are relatively not as skilled in program evaluation as they are in service delivery. Even if there were sufficient resources, this lack of expertise would hinder the quality of program evaluation.

8) Strategies for Reducing Service Gaps--This section offers some strategies for reducing the apparent limitations in the measurement of program effectiveness. These strategies are divided into short term--those that could happen within the next 5 years, and long range--those that will take more than 5 years.

a) Short term

(1) DD Planning Council establishing a consultant position(s)--an evaluator(s) who could provide consultation to early intervention programs throughout the state to assist them in the planning, implementing, and monitoring of an effective program evaluation strategy.
(2) State or regional bodies which are mandated to monitor local programs requiring that the programs aggregate their data or complete information sheets on individual children which could then be aggregated by the overseeing body.
(3) Various state bodies offering consultation in evaluation to the local programs which are governed by their mandates.
(4) Begin to work toward attitude change through educating adminstrators and practitioners to the benefits of having "hard data" to show the tax-paying public the benefits of the programs.
(5) State agencies acting as a clearing house to funnel information to local programs on innovative strategies for doing controlled studies and other tips to make the measurement of program effectiveness appear to be a reasonable and manageable task.

b) Long term

(1) Working with educational and training institutions to develop and implement a curriculum which has a greater emphasis on program evaluation.
(2) Program continued work toward attitude change with administrators and practitioners already in the field as to the benefits of assessing program effectiveness.

(3) Educational efforts with legislators and other funding sources to help them understand the benefits of assessing program effectiveness.
(4) Encouraging the field to adopt a theoretical framework regarding the measurement of program effectiveness in order to make evaluations easier to compare.

Of real concern is that the current situation of tight money seems to be leading to a change in mandates relating to the monitoring process. The movement is toward less monitoring of programs by state and regional bodies. Thus, it seems imperative that strategies which can convince practitioners, administrators, and the general public of the benefits of knowing whether a program is effective be implemented.

STAFF TRAINING

1) Definition--Evidence that program staff have appropriate and sufficient training experience to meet client needs and that continuing in-service training is provided to maintain and upgrade staff knowledge and skills.

2) Mandates Across the State--All children service providers have established certain prerequisite academic preparation, credentialing or licensure of their staff. Most provide staff with instruction regarding in-house policy interpretation/changes and procedures on a consistent basis.

   Service mandates may require various agencies to interact during the delivery process. However, staff training rarely addresses, detailed, formal, ongoing instruction regarding coordinating with specific "other" agencies/entities. General observation and informal discussion with professionals from several fields are the basis for this conclusion.

3) Quality, Comprehensiveness and Range of Services--Staff training as it relates to "in-house" operations is as comprehensive/extensive as the service mandate and resources to implement the mandate. The more specific the mandate and the requirement for accountability of its implementation, the higher the quality and comprehensiveness of services.

   Since all things are not and should not be mandated, much should be done to motivate staff to "pioneer" beyond the current rules. State planners and officials must ensure that their local staffs are equipped with the knowledge of the rules and resources. Personnel must be motivated to make an extra effort to surpass a given rule. It is imparative that we place "the staffs" extra effort in the realm of "pioneering" and not from the realm of "breaking the rules." Then and only then can we expect top quality and maximum comprehensive service delivery.

4) Service Gaps--The Early Intervention Task Force identified the following "elements" as contributing to gaps in services:

   a) A reluctance . . . to be aggressive . . . because of the lack of mandate . . . to provide services.
   b) (The identifying agency) does not always refer the child . . . for follow-up services.
   c) Program eligibility is not comprehensive. Client income, level of delay, age, etc., impede interagency coordination and timely service delivery. High risk children have fewer options.

   All of the above mentioned "gaps" can be addressed from the perspective of staff training.

   (1) People are usually hesitant to do anything when the rules are not stated or understood. Many interpret "no mandate" as meaning "the service should not be attempted." The employee assumes a big risk if he/she should attempt to initiate an unmandated service.

   Also, supervisors and planners do not support or encourage lower level employees' efforts to go beyond a specific mandate. Red tape, legal ramifications, and the "lack of reward" for efforts contributes to building gaps.

If we are to close the gaps, we cannot expect every service to be mandated. Staff must be provided training and support to explore unmandated comprehensive follow-through.

(2) Individual agency policies govern eligibility requirements. The regulations will take time to change. However, staff can be instructed regarding current procedures, schedules, and client requirements for service linkages with other agencies. Some of these linkages for instruction could include identifying/referral to parent support groups, alternative "at-home" activities for the child/family, recommending literature/other aids.

Other service gaps related to staff training are:

d) The lack of funds and administrative support to enable staff to participate in various training opportunities.

(1) Often administrative efforts to provide mandated or enhanced services are hindered because funds are not available to allow staff to participate in in-services sponsored by other training entities. Interagency coordination projects are impaired as a result of such lack of involvement.

If training monies are available, administrators are often reluctant to allow their direct service staff time off to participate. This is particularly true in the day-care arena. Most day-care facilities do not provide mainstream services. One reason is for this is that staff is not adequately trained; and therefore services are limited to services for the "non-handicapped" only.

e) Often the training that is provided by universities, other agencies or professional organizations is not relevant to the needs of staff.

(1) Training developed by outside entities is often prefabricated and developed without input from the intended audience. Such training is usually developed to meet the trainers' objectives and not necessarily the needs of the staff trainees.

5) Barriers to Services--The barriers as identified by the Early Intervention Task Force are:

a) Lack of commitment to prevention by citizens, legislatures, and officials.
b) Some professionals do not believe early intervention makes a difference.
c) Some professionals lack . . . training to identify, locate, and evaluate young children; professionals are reluctant to identify and assess children when they know "how to" because of the possibility of "mislabeling" a young child for life.
d) Lack of a strong mandate and resources to provide comprehensive developmental services for children.
e) Lack of and cost of transportation services.

Staff training is directly relevant to items a, b, c, e, of this section. Most professionals and agencies work in a void when "preparing" personnel for appropriate service delivery. Each locks itself into its particular discipline. Many neglect to account for and understand the impact of other disciplines upon their work and clients' progress. Interagency/interprofessional in-services may be a means of providing personnel with knowledge of how their performance can impact upon officials', planners', parents', and legislated policy decisions/activities.

Staff must be trained regarding methods of reporting/documenting for program change/improvement. They must be provided feedback regarding their concerns and be allowed to participate in reaching solutions for identified service problems. Interagency task groups is another excellent method of addressing issues and providing training for officials and managerial personnel.

Agencies which have regular contact with parents should provide organized instruction for parents regarding: 1) available services; 2) parent/client responsibilities; 3) procedures for securing/maintaining service follow-through; 4) program/service limitations; and 5) personal development activities (when possible).

6) Strategies for Reducing Service Gaps--

Issue a	Short Term	Long Term
A reluctance . . . to be aggressive . . . because of the lack of mandate . . . to provide services.	1) Agencies to clarify in-house regulations as needed; explain that mandates may fall short of comprehensive service delivery; clarify in-house procedures and/or strategies for extending services beyond a given mandate. 2) Encourage, monitor, record and support "pioneer" efforts of staff that extend services beyond mandates that are within the boundaries of current agency policy; assist with policy interpretation. 3) Provide staff recogniton and support for extra effort/concern; an in-house staff newsletter can be excellent for staff morale if used properly; place written summaries of individual staff accomplishments/involvement in personnel files. 4) Parents must be considered the key to service delivery. Provide staff with resources/information needed to assist parents in follow-through with responsibilities. Parents should be aware of their roles, service limitations etc., early in the planning stages of individualized programming.	1) Provide local interagency administrative "Planning Conference" of two or three agencies' officials; share data, review policy problems between agencies; jointly plan client transitioning and referral procedures; schedules, etc., jointly develop information to the public; jointly develop position papers, etc. 2) Utilize documented "pioneer" efforts of staff to influence future policy mandates; share documented pilot procedures/summaries with programs in other locations with a similar problem. 3) Utilize the news media to provide the public with program data. One news release should depict data regarding several local/state agencies; data could be useful to staff training and interagency planning.

Issue b	Short Term	Long Term
(The identifying agency) does not always refer the child . . . for follow-up services	1) Establish local exploratory interagency projects to address a specific service delivery problem; pilots could be used to develop/test possible solutions and act as "on the job" training mechanisms for individual agency staff/program development, a allow the lower level staff to explore a framework for solving the problem.	1) Survey agencies to determine if training is provided regarding interagency coordination and coordinating with parents.
	2) Document/communicate interagency activities to program officials and public.	2) Provide interagency/interprofessional staff incentives and in-services.
	3) Educate staff and professionals regarding "how" to relate to your program's clientel; educate clients regarding "how" to coordinate with agencies.	3) Children's service agencies must make the "extra effort" (on behalf of staff) to document and reward professionally, personally and programatically; outstanding work.
	4) Develop written generalized "how to tips" for use by public, e.g. provide directories, handouts, etc.; place such materials in churches, doctor's offices and other strategic places.	4) Establish local interagency task (lower level staff) groups to identify, prioritize service delivery problems; group should select one problem to address during a year; allow task groups to be ongoing with new membership every year.
	5) Provide professionals/independent practitioners with updated program information; invite them to participate in in-house in-services and/or advisory groups.	5) Provide state/national policies which emphasize the practice of interagency referral and coordination.

Issue c	Short Term	Long Term
Program eligibility is not comprehensive. Client income, level of delay, age, etc., impede interagency coordination and timely service delivery. High risk children have fewer options.	1) Establish local interagency task groups (administrators) to identify policy gaps and explore solutions and/or alternatives; plan staff training. 2) Document/communicate in-house policy gaps to officials for staff training/planning. 3) Establish pilot projects to explore interagency gaps; plan interagency training regarding findings and solutions.	1) Utilize interagency approach when influencing legislation and changes in regulation. 2) Administrators may jointly seek funds to operate special one-time projects, interprofessional training, etc.

Issue d	Short Term	Long Term
The lack of funds and administrative support to enable staff participation in various training opportunities.	1) Pool interagency funds for staff training to minimize training cost per agency. 2) Provide a staff training needs assessment for use in planning future staff instruction and obtaining funds. 3) Utilize a portion of program monies to obtain relevant training packets, workbooks, etc. which would enhance staff performance; seek "self-help" materials; make such materials available to appropriate personnel. 4) Encourage staff to take advantage of available low-cost or no cost training resources/activities; provide needed administrative support. 5) Allocate a portion of program funds to accommodate staff participation in relevant training activities.	1) Educate administrators, policy makers, etc. regarding the importance of ongoing coordinated staff instruction. Persistantly request and provide justification for additional money for the purpose of staff training. Provide program officials with feedback regarding training results and service improvements which result from enhanced staff performance.

Issue e	Short Term	Long Term
Often the training provided by universitites, other agencies or professional organizations is not relevant to the needs of staff.	1) Economically select training providers which best accommodate the needs of staff, program and clientel. 2) Participate in developing training which is intended for program staff; beware of "prepackaged" instructional events and activities; thoroughly investigate all prefabricated training materials and/or events. 3) Obtain feedback from staff as to the relevancy of instruction implemented by outside providers. 4) Inform training providers of specific training needs and concerns.	1) Inform training providers of specific training needs and concerns. 2) Do not provide support letters, for providers who seek grants to implement training if the training has little or no value to programs and staff. 3) (Via an interagency approach) inform funding sources of training concerns, trends, etc.

7) Summary--Training is planned ongoing staff instruction provided to enhance personnel performance and service effectiveness. Children's service agencies throughout Ohio implement some form of staff instruction during a given program year. However, there appears to be a need to provide training which addresses specific elements of interagency service coordination and coordination with parents.

Changes in state/federal regulations/practices are necessary to ensure long term improvement in the delivery of services to children. Short range improvements can be initiated by educating agency personnel, professionals and parents about gaps resulting from "human factors" in the delivery network.

Staff must be encouraged to function beyond program mandates. They must be given the administrative support and policy guidance which will enable them to go beyond a particular mandate and yet function within the current program policies.

Parents must be viewed and treated as part of an "extended staff" unit within the delivery network. Clarity regarding agency terminology, service limitations, program/parent responsibilities and schedules should be considered as major training needs for all levels of staff of children's programs. Agency personnel must be sensitized to the needs of parents, so that parents may appropriately follow-through with their responsibilities in a timely and well organized manner.

Interagency in-services and incentives could be useful in eliminating service gaps resulting from a lack of understanding "other" agency requirements, policies and procedures.

Money and administrative support are badly needed to enable staff to participate in a variety of available training opportunities. Training sponsored by universities could be utilized as staff incentives.

Professional organizations, other agencies and universities which develop instructional information and activities for program staff need to obtain input from the intended audience prior to developing training packets/events. All staff instruction should be consistant with the needs of staff, programs, and clientele.

THEORETICAL ADEQUACY AND CONSISTENCY

1) Definition--"Evidence that the treatment program represents a consistent programmatic approach based on the best available knowledge regarding the prevention, amelioration or rehabilitation of processes which cause or complicate developmental disabilities in young children." The question basically is, "Does the program have an underlying philosophy which is consistently adhered to, and is this philosophy currently theoretically sound?"

2) Issues--In regards to having a mandate for theoretical adeuqacy and consistency, half of the Task Force represented agencies which said that they had a mandate. However, there is some uncertainty as to whether Task Force members were actually discussing the mandate for a philosophical base or the mandate for services described by the philosophy. Task Force agencies felt themselves to be good (average score 4 out of 5) in terms of quality and range of services. This element's gaps were described as lack of geographic consistency and a lack of commitment to this concept (theoretical adequacy and consistency) when programs are turned over to local community groups to administer. Barriers included weak or nonexistent mandates and cumbersome bureaucratic procedures which delay making official changes in policy to keep them in accordance with the latest research. Another barrier was the dwindling resources of staff and funding to ensure that research continues and the research data is assimilated into agencies' philosophies. Possible strategies to overcome gaps/barriers could involve: 1) stronger mandates by agencies when addressing this issue; 2) more specific interagency agreements between central agencies and local providers to abide by philosophical and research issues; and 3) increased resources to ensure that agencies have sufficient staff and funding to keep their programmatic approach theoretically sound.

3) Summary--In conclusion, the element of theoretical adequacy and consistency was one that Task Force members may have interpreted differently due to an unclear understanding of the terms. Represented agencies felt positively about their involvement with this element, although gaps and barriers were identified. Enactment of suggested strategies to overcome these gaps and barriers may be prohibited by restricted resources and be agencies placing a higher priority on more service-oriented issues.

FAMILY SUPPORT

1) Definition--Family support is defined as counseling, guidance and assistance to parents and families of handicapped children. Such services can include accurate information concerning the child's condition and needed services which may be supportive, referral, follow-along, transportation, assistance with daily activities, financial counseling, parent training, and/or respite care. Family support services are geared toward helping the family cope with crisis situations and ongoing problems and needs, helping the family to participate in the planning of long and short range goals for the disabled person, helping to coordinate the service program with the home, and helping the handicapped person to apply skills developed in school.

2) Mandates--

   a) Home Based Services--Rules Governing County Boards of Mental Retardation and Developmental Disabilities mandate the following program options: a) written instruction for families; b) "hands on" instruction and counseling, guidance, and assistance to parents and parent education.
   b) Early Childhood and Supportive Home Services--P.L. 94-142 requires full parent participation in the IEP/Placement Process.
   c) Preschool Incentive Grants, 94-142.
   d) Education of the Handicapped Act, 91-230, Title 6-D.
   e) Information and Recruitment E.S.E.A., Title 6-D, Sec. 633.
   f) SSI Disabled Children's Program, S.S. Act, Title 16, Sec. 1615-B.
   g) Handicapped Children's Early Education Program, EHA, 91-236, Sec. 623.
   h) Education Innovation and Support, E.S.E.A., 95-561, Title 4-C.

3) Quality, Comprehensiveness and Range of Services--

   a) The developmental Disabilities program has made an effort to let grants that will respond to these needs. (Respite care, etc.)
   b) Parents participate in IEP process and placement.
   c) County Boards of Mental Retardation and Developmental Disabilities provide parent education/parent training/parent counseling programs.
   d) County Board of Mental Retardation and Developmental Disabilities and/or Department of Mental Retardation and Developmental Disabilities may provide case management services.
   e) Grants from U.S. Department of Education such as BEH Project.
   f) Regional Resource Centers offer training programs for parents.
   g) Parent/infant early childhood programs usually involve parents to a high degree. Sometimes include a social work component.
   h) OARC, Autism, UCP offer parent support groups.
   i) SSI Disabled Children's Program provides care management and counseling.
   j) Parent to Parent--Down's Syndrome, etc.

4) Service Gaps--

   a) Once grant period has expired, the DD Program does not seem to have ensured that a generic agency will provide continuity of services.

- b) The Department of Mental Retardation and Developmental Disabilities has an inadequate case management system.
- c) Parent training programs are sporadic and spotty rather than consistent and continuous. (Geographical and overtime)

5) Barriers--

- a) Case managers are not well informed of existing community services or how to use them.
- b) Services are offered to all families but participation on the part of each family is optional.
- c) Bureaucratic systems seem impossible and complicated to parents.
- d) No clear directives/mandates/administrative rules fixing responsibilities.
- e) Resources are diminishing and projections are for a slow growth economy for the next ten years.
- f) Services are dependent upon local attitudes, resources, education, and promotion.

6) Strategies--

- a) Short term
  - (1) Hold on to what we have.
  - (2) Try to reactivate parent support groups that have been active in the past.
  - (3) Pass Human Resources Bill.
  - (4) Facilitate setting Medicaid Waiver for Ohio so Title XIX Funds can be used for respite services.
- b) Long term
  - (1) More parent and professional education regarding services (available and needing development).
  - (2) Change attitudes of parents and professionals regarding parent involvement and responsibility--parents as their own case managers.
  - (3) Extend coverage and fix responsibility for laws and rules we now have.
  - (4) Train parents to be peer counselors and support persons to other parents.
  - (5) Research support services models for parents that have proven effective and are used by parents.
  - (6) Evaluate effectiveness of four parent projects currently sponsored by the Ohio DD Planning Council.

CASE MANAGEMENT SYSTEM

1) Definition--The assignment of a specific person responsible for assuring, documenting and evaluating the continuity of care for an individual developmentally disabled person throughout all phases of treatment both within a given agency and across agencies. This person may be located either within or outside the service providing agency or agencies. The case management system should allow for review and redirection throughout the life span of the client as well as provide standby availability to assist the individual with both anticipated and unanticipated problems without creating dependency needs.

   Case management should be a systems approach, i.e., "an orderly way or method, encompassing many parts, to help in and secure respectful arrangements for advantageious aid to others."

   The design must assure accessible entry, ensure continuity of service and be manageable. The processes involved are well defined to include specific activities, mechanisms and desired results.

2) Case Management System in Ohio--In the State of Ohio, the responsibility for the process of case management for developmentally disabled persons or handicapped children is extremely difficult to identify in department mandates. In most departments, it is an "encouraged activity." The materials submitted from the task force indicate the Departments of Health and Public Welfare have been given the authority and responsibility in a defined manner to provide case management. This authority rests in the Social Security Act amendments and pertains only to Social Security related eligible recipients.

   The case management system concept and implementation in Ohio is therefore very vague and unstructured.

   One acceptable generic model of a case management system includes the components of direct service management, information management, and assurance of service continuity from in-house and other community resources. Inherent in these components are intra and interagency coordination, advocacy for service needs awareness, recruitment and maintenance of a service provider network, and education of consumers, providers and professionals. The case manager is the pivotal key to the effective mobilization of resources in order to enable the individual to reach the optimum of his/her well being.

3) Service Gaps--Every child residing in the State of Ohio with a handicap or a suspected handicap should have an equal opportunity to be provided with appropriate core services supported by the orchestration of all available resources to meet additional needs. The implementation of this obligation is less than acceptable.

   a) While there is consistent reference to the assurance of counseling, guidance and assistance in most program guidelines, there is an apparent lack of integration of a case management model in the program plans. The lack of understanding about the case manager's role is reflected in the individual agency's concentration on its own specialized service while leaving the support system vaguely to someone else.

b) Service requirement differences and eligibility conflicts contribute to service gaps. There is little consistent intervention by an assigned case manager who is flexible enough to move beyond the limitations of a program or who when limited can align the youngster in a planful way to continue the case management service.

c) There is a distinct lack of parent involvement in most of the identifiable case management systems. The services to the child are managed in some respects, however, the impact on the family and/or its environment, and the resultant need for parent decision making is not consistently addressed.

4) Range of Services--The comprehensive nature of a state and local case management system varies greatly across the state and within departments. In some state agencies, it is perceived as information management only. In others, the direct service component is more strongly addressed. Combinations of the components are usually found working somewhat effectively at the local level generally through the creativity of individuals. In some programs children are identified, assessed, evaluated, and referred in a timely way utilizing a comprehensive approach in networking all supportive services. In other programs, referral systems are promoted with little follow-through. Continuity of service and coordination to meet other needs of the child and/or family is sporatic.

5) Quality--The quality of each of the components of the case management system varies greatly across the state. The quality of services that a young handicapped child and his/her family receives depends upon the strong commitment of the primary care agency, or the agency who initially identified the youngster, or where the child lives within the state. Interestingly, a child living in a nonmetropolitan area is more likely to receive more planful organized services within the options available due to the personalized nature of case management.

6) Barriers to a Comprehensive Case Management System--

a) Lack of understanding and commitment on the part of the legislature and public officials to the concept that prevention and early intervention with a comprehensive all encompassing continuum of care for young children with or at risk of having handicapping conditions benefits the child, the family and society personally and economically.

b) Attitudinal differences among professionals in embracing the concept of management of services is another barrier. The age old turfdom issues still prevail. Some research and demonstration projects have produced evidence that delegation of case management responsibilities is more effective and certainly more cost effective in utilization of resources.

c) Lack of appropriate training for professionals related to the concept. The skill limitations in the recognition of and appreciation for the case manager's role in any human service discipline is very high.

d) Lack of a strong, identifiable case management system structure within programs. Federal guidelines within certain programs such as EPSDT and the SSI Disabled Children's Program specify activities, time frames and documentation. While these requirements are workable, the mandate for the provision of timely services always seems to be challenged by direct service providers who are not aggressive in reducing barriers to that obligation.

e) Funding levels for the implementation of a viable case management system within departments at the state level is almost nonexistent. Automated systems exist in some major state agencies but little data is exchangeable due to noncoordinated system designs. Professional staff specifically assigned case management roles are identified in the Departments of Health, Public Welfare, and Mental Retardation and Developmental Disabilities, but their numbers are miniscule and their priority is low.
Community unawareness of the fragmentation of service delivery to youngsters in Ohio is another barrier. Individual and community support of programs is generally based on some degree of knowledge and the recognition of one's responsibility to society. There continues to be some denial of the existence of the need to serve the handicapped population especially children, and that need requires the more refined assembling of resources.

7) Strategies

a) Short term

(1) Professionals should take every opportunity to share recent research and demonstration findings regarding the efficacy of planful and organized case management models.

b) Long term

(1) A state-wide training network should be established to introduce, enhance, and promote the case management concept among professionals. They in turn could begin pilot projects within their programs to demonstrate the concept. Research data could lead to the promulgation of policy and procedures to specify the role and responsibilities of a comprehensive case management system.

(2) Agencies and organizations which are influential in establishing public policy should be informed of the high cost of the current fragmented system of service delivery to handicapped children and to the value of prevention and early intervention within a state-wide organized case management system. These entities should be nurtured as advocates for such a system.

(3) A single state agency should be designated by the legislature as the lead agency for the coordination of early intervention services for all developmentally delayed children, ages 0-5, in the State of Ohio.

(4) State departments should mandate within their organizations that a strong case management system with all components be developed. Simultaneously, a state-wide structure for management accountability should be developed.

(5) The lead agency would be considered the primary case manager to serve this population of youngsters. The agency would specify and standardize the process of comprehensive case management to include the timeliness of delivery activities, documentation requirements, minimum standards of a data system, and standards for assurance.

(6) This lead agency would be the primary custodian of all data related to this age population and services management in Ohio. This data should be used for reporting to all concerned parties and to attract federal financial participation in improving services.

(7) This lead agency in concert with other appropriate state and local agencies, should provide on a continuing basis a training curriculum directed to the various roles in the case management system of parents, providers, consumers, practitioners, and/or clinicians, and case managers.

(8) Universities and colleges need to evaluate their curriculum for health, educational, and social work professionals to assure understanding and skill acquisition in the case management system and the roles therein. Human services management at all levels (direct to administrative) should be emphasized.

Respite Services as a Component
of
Comprehensive Family Support
A Position Paper

Prepared by -
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Ohio Society for Autistic
Citizens

Before beginning a discussion of critical issues relevant to the development of respite services, it is important to first briefly describe the role of basic family support services. This is necessary because respite services are most appropriately viewed as a type of family support.

FAMILY SUPPORT SERVICES

> "The best place for children to grow up is in a family setting."
>
> "Government policies should help support and maintain family stability."

It's hard to disagree with these two statements. However, our agreement about the importance of the family has not always resulted in the development of government policies which help maintain family stability. This is especially true for parents with disabled sons or daughters.

Until fairly recently parents were offered two alternatives:

- try to keep their child at home, without supports or services

or

- commit their child to a large state institution

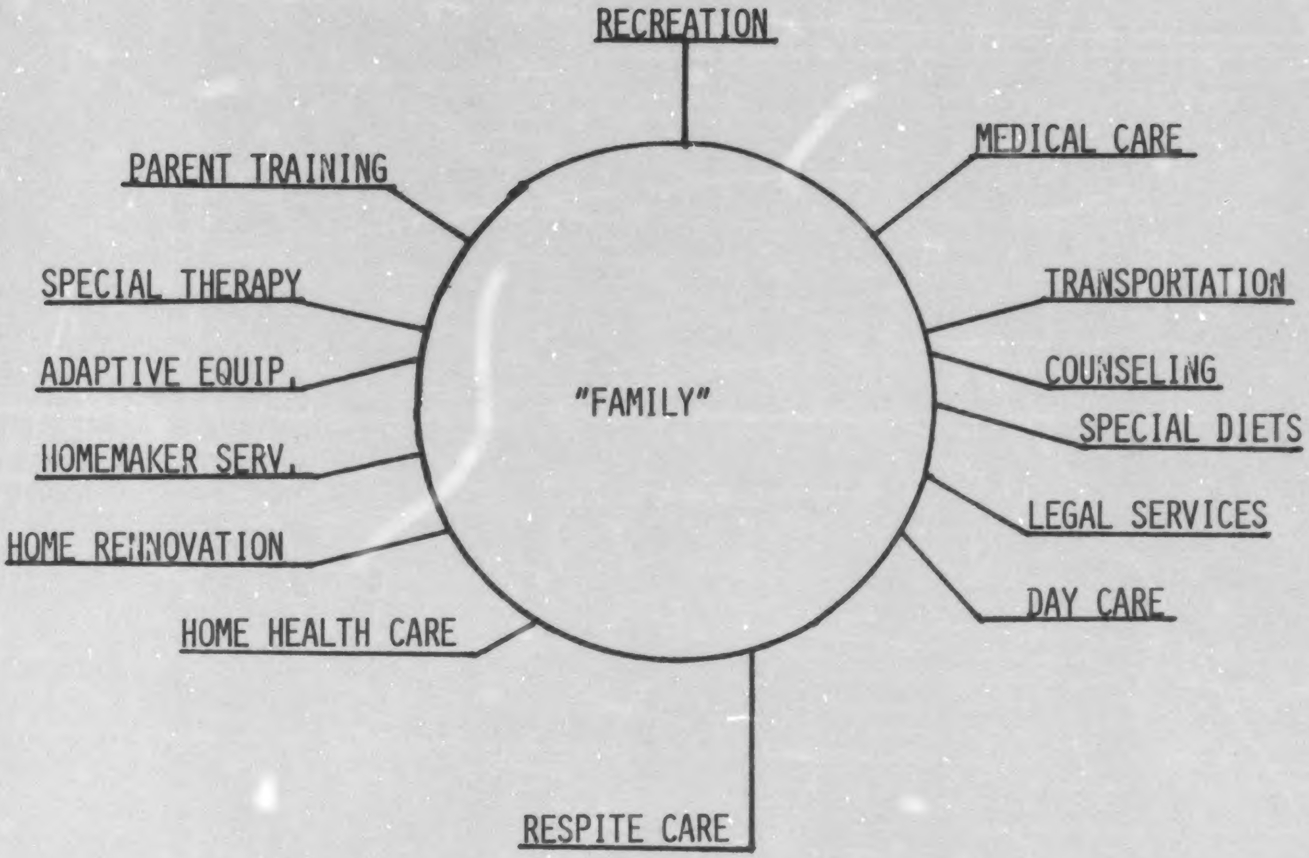
Parents were basically in a "no win" situation.

Things have begun to improve--now parents are often provided other alternatives, such as foster homes, family homes and group homes in the community.

One thing however has not changed--the major service options available to parents require out-of-home placement. Many parents are forced to place their son or daughter in an out-of-home residential system, at great expense to the taxpayer, because much more economical family support services are not available. Other families choose to keep their son or daughter at home, even though little if any supports are provided. These families often pay an enormous emotional and financial price for their decision.

Most families don't want out-of-home placement, but they do need help. They need respite services to deal with crises, to allow for planned vacations, sometimes just to go to the movies. They may need help in purchasing adaptive equipment or they may need special training and in-home assistance to deal with serious behavior problems. These services are not available in most communities and when they are available, many families cannot afford them.

We must begin to develop comprehensive plans which will result in an array of family support services. The figure on the next page illustrates this approach - it shows the family as the focus of concern, effort and resources.


RECREATION
MEDICAL CARE
PARENT TRAINING
SPECIAL THERAPY
TRANSPORTATION
ADAPTIVE EQUIP.
COUNSELING
"FAMILY"
SPECIAL DIETS
HOMEMAKER SERV.
LEGAL SERVICES
HOME RENNOVATION
DAY CARE
HOME HEALTH CARE
RESPITE CARE

What are Respite Services?

To most people the word "respite" means something like - "temporary rest from labor, effort; temporary cessation or postponement, usually of something disagreeable; an interval of rest or relief." It's clear that the need for respite of some kind is universal - we all need relief or rest from time to time.

Within the context of a family support system, respite services could be defined as those services which are designed to provide families with a temporary period of rest or relief from the responsibilities of caring for their disabled son or daughter. For the specific purposes of this paper, our discussion will focus on those programs which are specifically designed to provide respite. Many programs such as schools, workshops, early intervention, etc., help meet the families' respite needs - but not as part of a formal respite plan.

Purpose of Respite Services

Like any other family support service, the ultimate purpose is to help maintain family stability, increase the quality of family life and allow for more family control over the decision as to when and if out-of-home placement is needed.

Respite services obviously help families deal with more immediate situations, such as:

- crisis assistance to help families during periods of stress, such as divorce
- a Saturday afternoon activity program which allows parents time to shop
- vacations - some families are able to go on vacations only because they have access to a respite program.

There are probably as many "purposes" for respite services as there are families which need service. It is very important for individual families to have the greatest possible freedom in determining their "purpose" or "need" for respite services.

For purposes of planning, family needs are usually placed in two categories:

- planned
- crisis

Planned needs usually reflect routine events such as vacation, afternoon, overnight and weekend services. Families typically plan to use respite services to obtain periodic relief from care responsibilities and to gain the freedom to do other things.

Crisis needs are obviously less predictable. The cause for the crisis may be related to the disabled person or it may be caused by other family situations such as divorce or death.

The major reason to make this planned versus crisis distinction is that, as you will see in the next section, it is very important in the planning process.

Types of Respite Service?

Far too often respite services are thought of only as the provision of a bed. Given the many different purposes for respite service, it is clear that no one type can meet the needs of even one family. The following table provides one way to organize our thinking regarding the different types of respite service which are necessary to meet family needs.

		LOCATION	
		In-Home	Out-of-Home
WHEN	Planned	#1	#2
	Crisis	#3	#4

We have already covered the "WHEN" dimension of the table - families have both planned and unexpected or crisis needs for respite. The "LOCATION" dimension shows that respite services can be provided both in and out of the families' home. It is not necessary to have a separate type of service or respite agency to meet the four different needs for service. The important point is for the respite service system to offer appropriate services in each of the areas.

For example, a "typical" sitter companion program could satisfy most of a family's normal, planned needs for respite service. However, that family may also infrequently have unexpected crisis and, based on the parent's preference and needs of the child, the respite service will have to be provided in the home. At other times, or with other families, the situation may call for the use of out-of-home services to meet the crisis - such as in the case of a divorce. Some families also prefer to use out-of-home services to meet their planned respite needs - their son or daughter lives in a respite facility for the weekend, while they spend time at home with their other children.

Below is a partial listing of the types of services which have been developed to meet family needs:

- Sitter/companion
- Behavior management specialists working in the home
- Homemaker services
- Home health aides
- Family-to-family respite cooperatives
- Foster homes used for respite
- Families trained to provide respite
- After school/work drop-off programs
- Evening activity programs
- Weekend programs and summer camps
- Group homes used for respite
- Community respite facilities
- Crisis homes
- Nursing homes/institutions

When discussing the types of respite services needed, it is also important to consider two other variables (1) the breadth of the service (2) the intensiveness of the service. By "breadth" we mean - can the program serve persons who are physically disabled, older persons, persons with minor medical needs? By "intensiveness" we mean - can the program serve persons with severe behavior problems, with profound handicaps, with medical needs which require skilled care? Often those families with the most severely disabled sons and daughters - who are often in the greatest need for respite - are excluded from existing respite programs.

History of Respite Services

The brief history of respite services has been a mix of success and failure; however, it has mainly been characterized by neglect. As is true with most other types of family support services, no state has developed even a minimally adequate system of respite services.

The "typical" respite program has:

- offered one type of respite service, usually a sitter/companion
- served one type of disability, usually mental retardation
- served a narrow age range, usually children
- not been affiliated with a larger, more well established service agency
- not been adequately funded
    - funding only for coordination,
    - parents paid providers
    - providers paid minimum wage or less
    - not all families in need were served
- not been able to provide adequate recruitment, screening and training of providers
- not provided adequate monitoring and evaluation of service delivery
- not survived

Even with all these limitations and problems, many respite programs have been of great service to many families.

In the past and even now, the major problem is that respite services have not been perceived as legitimate, normal services which parents have a right to expect. It is ironical that a service so highly valued by families, that has a proven track record of cost-effectiveness, which is so consistent with fundamental principles of normalization and legal rights, receives the least resources and attention of any service.

Need for a State Plan

A state plan or set of systematic guidelines should be developed. The plan would be used to establish a set of rules and regulations which regions and counties could use to establish family-support systems. At a minimum the plan should reflect the following basic issues.

1. Respite Services - Part of a Family Support System

A plan for the development of a comprehensive family support system should be developed - with respite services functioning as a basic important component. Even if it is not now possible to fully implement all the various components, the overall plan should be developed. This would allow for the development of a respite system that is consistent with and supportive of the other family support components.

It would also reinforce the basic purpose of respite services - which is family support. This would help counteract popular conception that respite services are not legitimate (as compared to residential services, educational services, etc.) and are a "luxury" which need not be provided.

2. Definition of Respite Services

-appropriate, short-term, care that is provided in a variety of settings to meet planned or crisis needs of families. Rules and regulations should allow a maximum of flexibility with respect to the following variables:

-how services can be provided

-how often services can be provided
-where services can be provided
-how long services can be provided

3. Purpose of Respite Services

The purpose of respite services is to increase the quality of family life, help maintain family stability and allow for more family control over the decision as to when and if out-of-home placement is used.

The purpose is not to simply provide extras - services which are not available to families without handicapped sons and daughters. Also the purpose is not just to prevent institutionalization or out-of-home placement. Families should not have to plead a need for out-of-home placement in order to be served. Many parents with disabled sons or daughters require extraordinary supports and services, simply to have the same opportunity for a quality family life.

4. Types of Respite Services

The plan should call for the development of a wide range of programs to meet both planned and crisis needs and offer both in and out-of-home services. It is especially important that services be designed to meet the needs of families with sons and daughters who have severe disabilities.

The plan should also take into account the already existing programs which indirectly provide respite services - such as weekend recreation programs, night time social programs, summer camps, etc. These programs should not be innappropriately duplicated.

5. Providers of Respite Service

The plan should allow for a mix of public and private providers. A certification process should be developed to help insure quality service - but should not be so regimented as to discourage provider development.

The plan should mandate that some agency of state or local government be required to develop needed services if other providers cannot be found.

The plan should also encourage the development of respite service systems - either through cooperative arrangements between providers or the development of single provider programs which are large enough to develop comprehensive, flexible services.

6. Consumer/Client of Respite Services

The family is the primary consumer - not just the parents or just the person with a disability. However the different needs of both must be taken into account. The reality is that the primary reason for the provision of respite care is to provide parents with temporary relief from the responsibilities of caring for their disabled son or daughter. However this purpose cannot become so all important that the needs and legal rights of the disabled person are neglected.

7. Administrative Structure/Funding

Given the mixed history of respite services it is clear that the plan should facilitate the development of respite programs which are well integrated and strongly attached to the existing service system. "Isolated" respite programs are the first to be eliminated during a funding crisis. This can be accomplished by having the respite providers be administratively tied to a larger service program (such as being part of a 169 program) or having the funding and control source be part of the larger system while the providers remain "independent."

The plan must help solve the major funding problem which is clearly that funds aren't available. The other major problem is that most respite providers are not paid a fair wage for the services they provide. Until adequate reimbursement is provided we will never be able to attract competent providers.

8. Staff Resources

The plan should facilitate the recruitement, screening and training of respite providers.

This is one of the weakest aspects of the current system. The plan should encourage the use of regional resources to assist counties in developing ongoing pre and in-service training programs.

9. Consumer Involvement

Primary consumers and parents should be involved in all stages of plan development and implementation. This variable is the most important and often least attended to of all the issues discussed.

10. Monitoring and Evealuation

The plan should call for systematic and ongoing evaluation of respite programs.

Respite program evaluation could probably be included as part of the "normal" program monitoring system and would not require a separate or unique approach.

POSITION PAPER NO. 2

RESIDENTIAL SERVICES IN OHIO

The Need to Shift from a Facility-Based to a Home-Centered Service System

Prepared by the Community Services Subcommittee
Deinstitutionalization Task Force

"ALL SUCH INSTITUTIONS ARE UNNATURAL AND UNDESIRABLE, AND VERY LIABLE TO ABUSE. WE SHOULD HAVE AS FEW OF THEM AS POSSIBLE, AND THOSE FEW SHOULD BE KEPT AS SMALL AS POSSIBLE. THE HUMAN FAMILY IS THE UNIT OF SOCIETY."

SAMUEL GRIDLEY HOWE
1866

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Summary

This paper originated with the Community Services Subcommittee of the Deinstitutionalization Task Force. The Task Force reviewed and modified the paper and accepted it as a position paper of the Task Force.

The purpose of this paper is to provide a statement of program philosophy and service strategies that can be used to develop quality residential services for persons with developmental disabilities in Ohio. It is not intended as a specific plan for the development of residential services.

The position paper:

- delineates the basic assumptions which should guide the planning, development and implementation of a residential service system.
- analyzes some approaches other states have utilized, i.e., continuum approach.
- calls for a residential system based on a home-centered approach utilizing supported natural living environments and small, integrated alternative living arrangements.

- provides a series of short and long term recommendations to begin the planning process.

The next step in the process is the development of specific plans to accomplish the directions articulated in this document.

This paper is one of several position papers developed under the auspices of the Deinstitutionalization Task Force. Appreciation is expressed to the individuals who participated in the development and review of this document.

Wade Hitzing
Ronald E. Kozlowski

Residential Services

The purpose of residential services is to assist persons with disabilities to live in settings which maximize their

PURPOSE

- independence and human dignity
- presence and participation in community life
- status as valued community members
- potential for growth and development.

It should be noted that these outcomes can be achieved without neglecting the person's needs for supervision and care and can be accomplished in situations which are typical of normal home life.

Basic Principles of Residential Services

VALUE BASED

A necessary first step in the development of any systematic approach to the delivery of residential services to persons with developmental disabilities is the delineation of the assumptions upon which the service system must be built. These assumptions reflect basic philosophical and judicial principles in the field of developmental disabilities and should guide the planning, development and implementation of the system.

LEAST RESTRICTIVE ALTERNATIVE

The principle of least restrictive alternative requires that an individual's living situation be the most age and culturally appropriate that can also meet the person's needs for supervision and training without imposing unnecessary modifications or denials of personal rights. A further consideration is that the selection of a particular living situation must be based on the person's needs and wishes—not just on what options are currently available in the service system.

There is a relatively simple test for dealing with the issue of least restrictive alternative. In trying to decide whether a specific living situation fits the criterion of least restrictive alternative one must ask whether there are examples of persons with similar needs, *being appropriately served*, in less restrictive settings. This type of test was critical to the landmark Pennhurst Case (Laski, 1980). The basic strategy of the plaintiffs was to show that for each resident living in Pennhurst (a restrictive setting) there was a person with similar needs who was being appropriately served in a less restrictive community setting. After being presented with many such examples, Judge Broderick concluded that an institutional environment was not necessary to meet the resident's needs— in that each

Pennhurst resident had a "functional twin" living in an appropriate, less restrictive community-based setting.

It is important to point out that the application of the principle of least restrictive alternative does not mean that we will be able to provide all persons with age and culturally appropriate, typical residential settings. However, application of this principle does require that placement of a person in settings other than these, be proven as necessary, to meet the person's needs. The basic planning assumption should be that all individuals will live in small, well-integrated, positively-valued settings. Any deviation from this strategy toward more restrictive settings may only be undertaken after proof that the person's needs cannot be met in less restrictive alternatives.

RIGHT TO TREATMENT

Right to treatment concerns the right of persons with disabilities, to services or treatments which promote growth toward increased independence and competence.

While it may be possible for persons to benefit from congregated and segregated programs, one can question whether such programs provide an appropriate treatment or service environment. Given that the ultimate goal for all persons is to, as much as possible, live in a complex, heterogeneous, community-based setting, the adequacy of any large, segregated setting must be questioned. How does the congregation of large numbers of persons with developmental disabilities in physically and socially segregated settings contribute positively toward enhanced independence, competence or social awareness?

NORMALIZATION PRINCIPLE

Normalization refers to "...the utilization of as culturally valued means as possible in order to establish and/or maintain personal behaviors, experiences and characteristics that are as culturally normative or valued as possible." (Wolfensberger, 1980) This principle calls attention to (1) what the residential program achieves for those to whom it provides services (the "goals") and (2) how the program achieves these objectives (the "means" in the definition).

Appropriate application of the normalization principle results in the development of residential services which ensure as much as possible the individual's presence and participation in typical community life, e.g., physical and social integration.

EQUAL JUSTICE

Adherence to the concept of equal justice requires that all persons with developmental disabilities be provided services and supports that will allow them an equal opportunity for growth and development. In a variety of different places across the United States persons with severe handicaps are being served in quality, integrated community settings (Apolloni, Cappuccilli, & Cooke, 1980; PCMR, 1978). The concept of Equal Justice requires that long range plans be based on the assumption that all persons can participate in this type of valued community life. As long as persons with disabilities are forced to live in restrictive segregated settings only because appropriate community alternatives have not been developed, the concept of equal justice would not have been appropriately applied.

RESPECT FOR HUMAN DIGNITY

While the respect for human dignity assumption may seem to be more abstract than the others, it is still extremely important. Most persons have personal characteristics and competencies which are valued by others. Also, they can advocate for themselves and are therefore usually afforded at least a minimum of dignity and respect. Except in very limited ways, persons with severe handicaps cannot gain the same degree of dignity and respect *by their own actions*. It is therefore extremely important that they be treated with respect and served in settings which are as *positively-valued* as possible.

DEVELOPMENTAL ASSUMPTION

Traditionally, mental retardation and other forms of developmental disabilities have been looked upon as "health problems" and services to persons with developmental disabilities have been structured on a medical model. Many needs such as communication, personal skills, home making, social skills, etc. were attributed to the person's developmental disability and viewed as being a sickness or physical problem remediable or met by medical approaches, settings, medicines and processes. Persons with disabilities were perceived as having limited potential. In part, institutional services were developed based on the medical model.

However, as knowledge about developmental disabilities has expanded, it has become clear that a developmental disability is *not primarily a health problem*. A disability is not the same as an illness, nor very often is there a cure. Developmental disabilities are conditions, stemming from physiological or psychological handicaps, which significantly curb or affect a person's development. If developmental disabilities are a developmental problem, then they must be approached as such. Human beings, by their nature, grow, change and develop and persons with developmental disabilities are no exception. The only difference is that a person with developmental disabilities needs specialized, sometimes long-term, help to develop as fully as possible.

The developmental assumption is considered by most people to be a desirable approach to serving persons with developmental disabilities and serves as a basis for valid service development. The developmental assumption is based on the following:

A. LIFE AS CHANGE - Human beings are in a state of change from the time of birth until death. The assumption that handicapped persons are often physically and psychologically fixed or unchanging, in effect, denies their humanness. All persons regardless of the type or degree of handicap have the potential for positive growth.

B. MODIFIABLE DEVELOPMENT - The rate of development is influenced by the interactions of many internal and external factors, including the individual's inherited characteristics, health and the external environmental setting. The rate and direction and ultimate level of development can be influenced through teaching and by utilizing and controlling certain physical, psychological and social aspects of the environment.

A primary goal of programs for persons with special needs should be to increase the adaptive behavior and general competencies of the individual by modifying the rate and direction of behavioral change. Persons with developmental disabilities should be approached from the standpoint of being capable of growth, learning and development. They should be considered in a state of constant change which can be significantly influenced by conditions imposed within the environmental setting. Persons with developmental disabilities have the normal developmental stages of infancy, childhood, adolescence and adulthood. Within each stage, different needs are emphasized. Although these stages may be delayed in varying degrees, persons with special developmental needs should not be subjected to socially imposed perceptions that limit growth.

The primary implication of the developmental assumption is that programs be oriented toward the individual, and program goals should be dynamic and individually defined. Residential programs should be designed to be as growth-enhancing and supportive of learning as possible. Institutional settings, which tend to congregate large numbers of persons with special needs and segregate them from normal community activities, are not consistent with the developmental assumption.

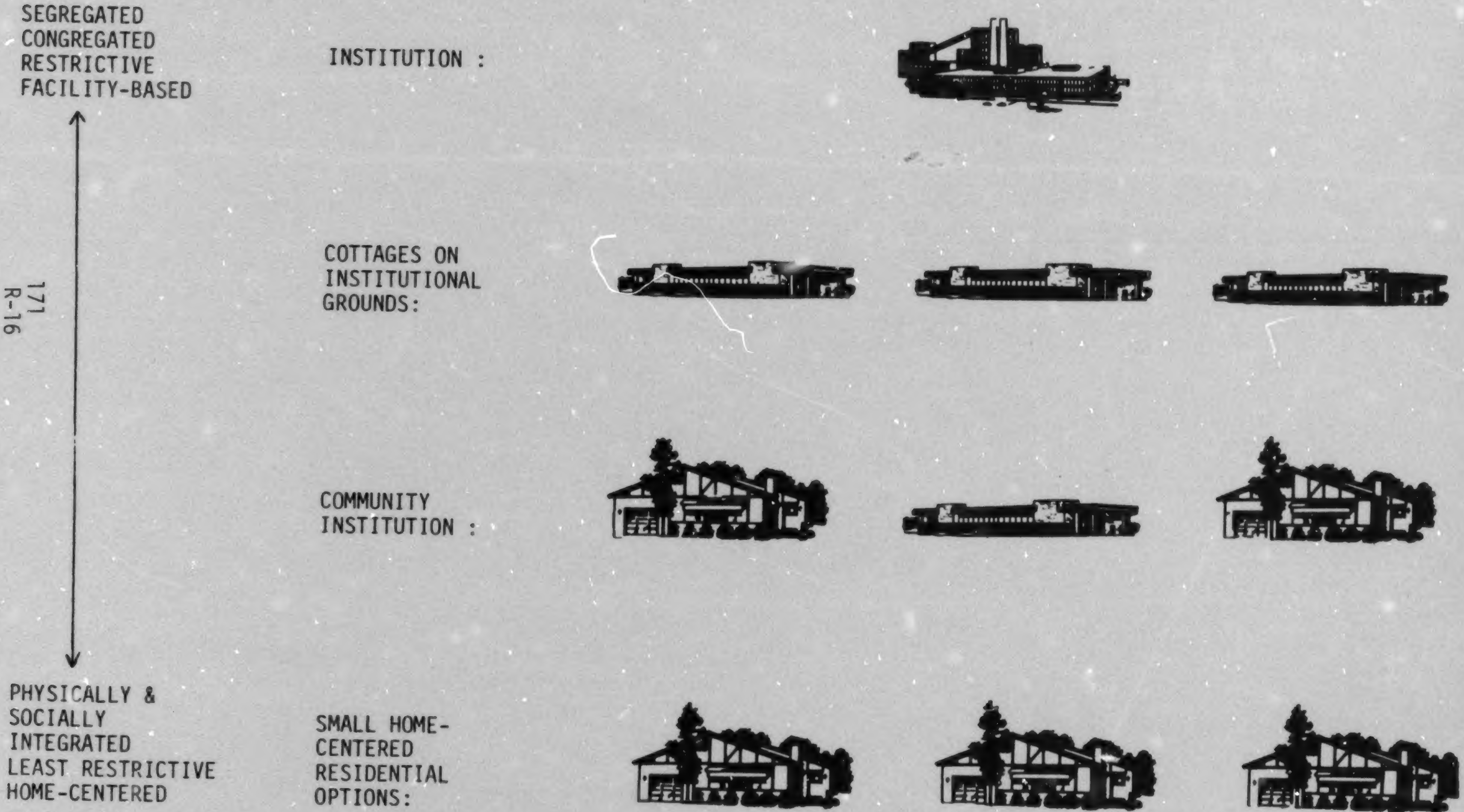
EFFECTIVENESS AND ECONOMY

The issue of effectiveness has already been dealt with, at least in part, in the discussion of the developmental assumption. It is paradoxical that one of the most frequently used rationales for congregate programs, providing effective service and treatment, is not supported by research findings (Pilewski & Heal, 1980; McCarver & Craig, 1974). Using a large segregated program as a training center best prepares the person to live in such a segregated setting. Recent research shows that it is very important, especially for persons with severe and profound handicaps, to participate in training programs which are as similar as possible to normal community settings (Martin, Rusch & Heal, 1982). It is especially important for persons with mental retardation because of their difficulty in generalizing from the training to performing environment.

It is also ironic that the other reason for the development of large programs, economy of service delivery, is not supported by available cost data. For example, studies have shown that smaller community-based programs can be provided at no more, and in some cases, less cost than institutional care (Touche-Ross, 1980; Lakin et al., 1982; Boggs, 1981). A number of states (Pennsylvania, Texas, Vermont, etc.) have limited or are in the process of limiting the size of community residential programs for persons with developmental disabilities (Toff, 1982).

However, there is an important complication to the economic analysis with which one must deal. Cost incentives and disincentives must be analyzed separately for each of the major "actors" in the deinstitutionalization movement. It is important to ask, "Cost savings to whom?" (the federal government, state or local government, the family, etc.). Although cost considerations are important, it is more important not to lose sight of the humanitarian considerations in providing small community residential programs.

Transition in Residential Services for Persons with Developmental Disabilities



SEGREGATED
CONGREGATED
RESTRICTIVE
FACILITY-BASED

INSTITUTION :

COTTAGES ON
INSTITUTIONAL
GROUNDS:

COMMUNITY
INSTITUTION :

SMALL HOME-
CENTERED
RESIDENTIAL
OPTIONS:

PHYSICALLY &
SOCIALLY
INTEGRATED
LEAST RESTRICTIVE
HOME-CENTERED

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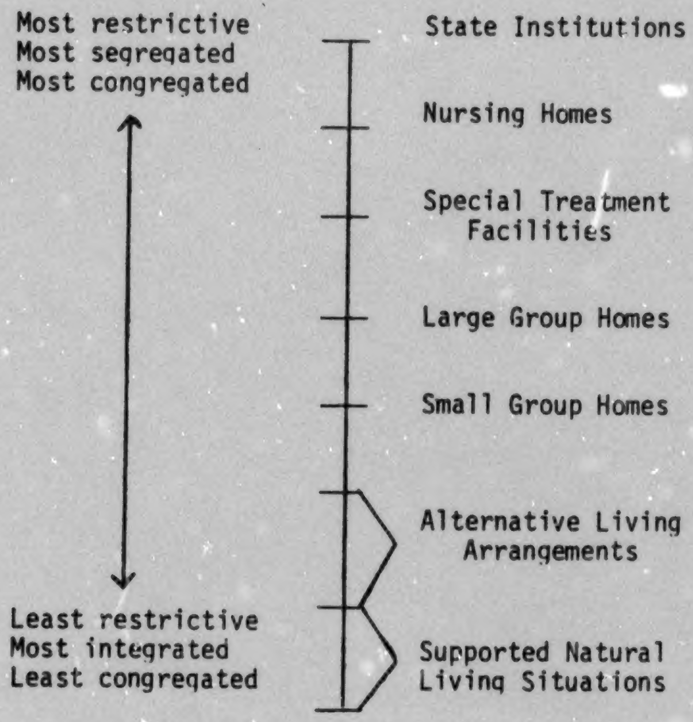
Critical Analysis of Current Plans in Residential Services

CONTINUUM APPROACH

Most states have long range plans that call for a continuum of residential services. The assumption is that different programs (usually based on different environments or settings) are necessary to meet the full range of service needs. An example of one such residential continuum is shown below.

RESIDENTIAL SERVICE CONTINUUM


Most restrictive
Most segregated
Most congregated
Least restrictive
Most integrated
Least congregated
State Institutions
Nursing Homes
Special Treatment Facilities
Large Group Homes
Small Group Homes
Alternative Living Arrangements
Supported Natural Living Situations

DEFINITIONS

- Institution: Large state operated residential facilities which provide a variety of services on a 24 hour a day basis and which have been traditionally separated from the general population.

- Nursing Home: A large community facility which provides health related or rehabilitative care and services to the elderly or chronically ill, e.g., skilled care facility, intermediate care facility.

- Large Group Home: A residential setting that provides room and board, personal care, habilitation services and supervision in a family setting. Typically serves 8 to 15 individuals.

- Small Group Home: A residential setting that provides room and board, personal care, habilitation services and supervision in a family setting for not more than eight persons with developmental disabilities.

- Alternative Living Arrangements: A range of residential options from semi-independent living (no live-in staff but with daily supervision and training) to residential settings for a small number of adults (less than 6) with full time staff supervision, and support, e.g., apartments, homes, etc.

- Supported Natural Living Situation: Living situation that is typical for a person's age or community, e.q., independent living with periodic support provided, individual living with his/her family, etc.

The continuum approach is based on the assumption that persons with the most severe disabilities are appropriately placed in more restrictive settings (nursing homes, special treatment facilities) and persons with less severe disabilities in less restrictive settings, with the rest of the individuals "spread appropriately" across the continuum. The hope is that if the continuum is comprehensive there will be no service "gaps"—all individuals can be placed in an appropriate program.

NEGATIVE ASPECTS

The development of such a comprehensive continuum does indeed offer advantages over our historical approach of offering only institutional services. However, there are a number of problems with the continuum approach.

RESOURCES GO TO RESTRICTIVE SETTINGS

1. Most of the resources go to the most segregated, most restrictive residential settings. Development usually begins with institutional reform, development of special care facilities and large group homes. Very few resources are then left to support more integrated alternative living arrangements and natural settings.

2. Movement from more to less restrictive

settings is presumed to be a function of improvements in the individual's behavior/ condition. The problems with this approach are:

FORCED TO EARN RIGHT

a. Persons with disabilities are forced to "earn" their right to live in less restrictive, more positively valued settings. Many persons, especially those with severe disabilities, will never "earn" this right.

"TYPE CAST" INDIVIDUAL

b. The entrance and exit criteria approach of the continuum strategy presumes that individuals can be "type cast"—group home type client, foster home type child, etc. If the person changes, he or she can move on through the continuum. This strategy reinforces the notion that certain persons can be served only in specific settings. Service programs are not seen as having any flexibility or elasticity for the individual's support.

LITTLE MOVEMENT THROUGH CONTINUUM

c. Studies have shown that there is not much movement through the continuum. One study reported that approximately one-half of community residential programs reported no movement in or out of their program in the previous year (Bruininks, Hauber, & Kudla, 1979).

MOVEMENT RESULTS FROM AVAILABILITY OF INTEGRATED OPTIONS

d. The continuum strategy presumes that persons move or "graduate" through the system as they gain in competencies and decrease maladaptive behavior. While of course this is sometimes true, it is clear that most moves through the system occur because of the development of more integrative service options. This is especially important for persons with severe disabilities. Most persons with severe disabilities will not earn their way to more typical, positively valued settings. However, a number of programs have shown that even persons with the most severe disabilities can live in small community-based settings if the service system is willing and able to provide the necessary supports.

REINFORCES "DIFFERENCES"

3. The continuum approach reinforces and deepens the perception of difference between persons with disabilities and other nondisabled

citizens. Much of our public education effort focuses on reducing this devaluing perception, yet success of such educational efforts will be diminished through the development of a continuum which ensure that nondisabled persons will not live near, nor go to school or work with persons with disabilities.

COST

4. The cost of fully implementing the continuum would be enormous. Most of the living environments on the continuum are "special" facilities which usually involves major renovation or [illegible] construction.

NOT POSSIBLE
TO PROVIDE
INDIVIDUALIZED
PROGRAM

5. It is not possible to provide a truly appropriate residential program in congregated, segregated settings. All of the specialized services and supports usually associated with segregated programs can be provided in more integrated settings. However, it is not possible to provide really individualized programs, with exposure to normal or typical role models in segregated, congregated settings.

Also persons with severe disabilities often have great difficulty learning new skills and even greater limitations in generalizing these skills to new situations. Research findings support a strategy of providing training in settings which most closely resemble the final living situation (Martin, Rusch, Heal, 1982).

Residential Services - An Alternative

HOME-CENTERED APPROACH

Persons with disabilities, both children and adults, should be supported in the most natural, most valued setting possible. Families should be supported (both financially and through supportive services) to help them keep their children with disabilities at home while growing up. Even with appropriate supports, some families will not be able or want to keep their children—adoptive and foster homes could then serve as alternative living settings.

Adults also should live in their "own" homes. Whether they actually own the building in which they live, is not as important as the understanding that it is their home—not simply a facility in which they live.

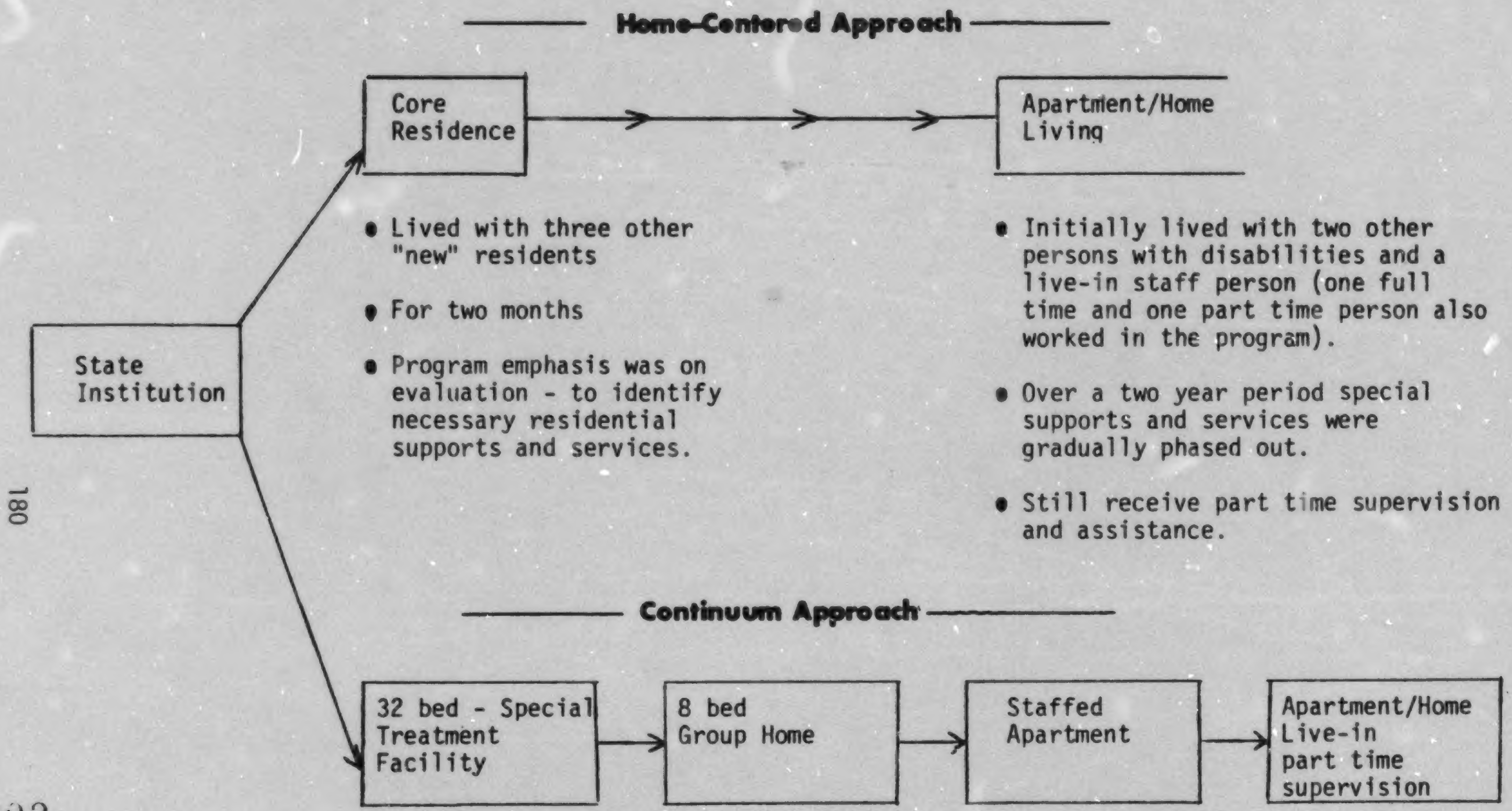
It should be noted that the concept of "home" and support of natural settings is not incompatible with the provision of highly specialized services and equipment, paid staff, etc. The continuum strategy, described in the previous section is based on the presumption that specific types and levels of care and supervision can only be provided in special, usually segregated settings. An alternative approach is to view natural environments as elastic and accommodating of differences and services as flexible and supportive (Galloway & Chandler, 1978).

ELASTIC AND ACCOMMODATING

Instead of employing the step-by-step "movement towards normalization." approach of the continuum, this approach calls for the movement of the individual to a situation similar if not identical to the "final" target setting. The provision of special, artificial supports and services are often required to accomplish this. However, for those individuals who later show gains in competence, such supports could slowly be removed. This type of approach allows for the development of much more individualized, more realistic training and living situations.

MOVEMENT TO "FINAL" TARGET SETTING

The major differences between the home-centered approach and the traditional continuum approach are displayed in the chart on the next page. For example, utilizing the continuum approach, an individual over a period of several years may be



Home-Centered Approach

State Institution

Core Residence → Apartment/Home Living

- Lived with three other "new" residents
- For two months
- Program emphasis was on evaluation - to identify necessary residential supports and services.

- Initially lived with two other persons with disabilities and a live-in staff person (one full time and one part time person also worked in the program).
- Over a two year period special supports and services were gradually phased out.
- Still receive part time supervision and assistance.

Continuum Approach

32 bed - Special Treatment Facility → 8 bed Group Home → Staffed Apartment → Apartment/Home Live-in part time supervision

- Initially placed in a special treatment facility because he did not meet the entrance requirements of the group home.
- After meeting criterion on self-care skills, was moved on.
- Program focus in group home was on decreasing problem behaviors.
- Moved to apartment with live-in staff; focus on community-living skills.
- Finally moved to a new apartment, still needed part time assistance.

MAJOR DIFFERENCES

required to make four residential moves. He or she would have to learn new relationships with approximately 25-40 staff personnel and about 25 to 30 other individuals. These changes could lead to considerable frustration and require additional "training" programs in each setting because previously taught skills did not generalize to the new living situation. Only in the final living situation does the individual begin to develop a feeling of home and permanence. In contrast, a home-centered approach would require the individual to make only two moves. He or she would have to learn new relationships with no more than 10 staff and five other residents. Within a short period of time, he or she would be in a home setting. Teaching programs, to increase both appropriate behaviors and competencies would then be provided in a typical, realistic living situation. Program costs could be reduced by gradually phasing out services and not by requiring the individual to move to a new setting.

Issues Specific to Children

FAMILY SETTING

The best place for children to grow up is in a family setting—preferably with their natural family. Functional support for this position involves the development of a full range of family supports—

through a variety of in-home supports and services (Hitzing, 1982).

For those children whose families cannot or will not keep them, adoption or foster home placement can still provide a family-oriented living situation.

FOSTER CARE

A major commitment to the development of a comprehensive foster care program would require a radical departure from the traditional approach to a foster placement. The few high quality foster placement programs which have been developed are characterized by:

IMPORTANT COMPONENTS

-A RELATIVELY HIGH LEVEL OF FINANCIAL SUPPORT TO THE FOSTER FAMILY

-EXTENSIVE BACK-UP SUPPORTS AND SERVICES SUCH AS IN-HOME TRAINING, CRISIS ASSISTANCE, RESPITE SERVICES, ETC.

-CONSISTENT PROGRAM MONITORING, EVALUATION AND MANAGEMENT.

It is clear that while the transition from a facility based to home-centered system is in progress, we would need to continue to support parts of our present facility-based residential service system. However, these programs would no longer be described as necessary to meet the child's needs. They are now and will continue to be necessary because we have not developed and supported natural and foster family settings. Accepting a family-centered approach to residential services for children would not require a call for the immediate elimination of all congregate, non-family living situations. However, if we were to accept a family-centered approach it would provide a positive long-term goal which could be used in decisions regarding resource allocation, service development, etc.

LONG-TERM GOAL

Issues Specific to Adults

DEPARTURE FROM FACILITY-BASED APPROACH

The application of a home-centered approach to the development of residential services for adults would provide a radical departure from our current, largely facility-based approach. The concept of a "home-centered approach" is much more complex and varied for adults as compared to the relatively simple family-based approach for children. No one model could be viewed as meeting the needs of all adults. A variety of options would be necessary, for example:

VARIETY OF OPTIONS

- INDEPENDENT LIVING WITH PERIODIC TECHNICAL ASSISTANCE BY A CASE MANAGER
- SEMI-INDEPENDENT LIVING, NO LIVE-IN STAFF BUT WITH DAILY SUPERVISION AND TRAINING.
- ALTERNATIVE LIVING ARRANGEMENTS, SMALL NUMBERS OF ADULTS WITH "FULL-TIME" STAFF SUPERVISION AND SUPPORT.

However, a home-centered approach would be inconsistent with any significant congregation or segregation of persons with disabilities. Twelve bed cottages are often described, especially in program brochures, as home-like. However, if you visited one you would never mistake it for a typical home.

ATTITUDE AND PHILOSOPHY

A home-centered approach would have an equally profound effect on the service attitude or philosophy of the residential program. Our current facility-based approach fosters an "our client," "treatment oriented," "us serving them" service mentality. A home-centered approach would emphasize the role of the residential program in assisting and supporting adults to live as independently as possible in the community. We would place more of our resources into support for independent and semi-independent living. For those persons requiring more care and supervision, small, well-integrated alternative living arrangements would be created. However, even in these small group settings the adults would be seen more as citizens who need special supports and services and less as "clients" involved in residential treatment programs.

INDIVIDUALS
NOT
CLIENTS

INDEPENDENCE
VERSUS
INTERDEPENDENCE

It is important to note that promoting the person's right to independence (i.e., personal control over decisions relating to his/her life) is not inconsistent with the concept of interdependence. Many persons with severe disabilities will always depend, to some degree, on support from a service system. Independence, if translated to mean isolated placement in the community without supports and without social ties, is not a legitimate goal. We must never lose sight that our purpose is to help persons with disabilities to increase the quality of their lives and not simply to meet the requirements of some abstract philosophical principle.

Potential Differences between a Home-Centered and Facility-Based Approach to Residential Services

Facility-Based	Home-Centered
Language	
Clients, residents, patients	Persons with disabilities
My clients, our residents, our population	The persons who live here
Group home, residential facility	House, home, apartment
Ravenwood, Brown Home #1, Guilding Light Center	2165 Upper Arlington Road
We program the clients 3-4 hours per day	We assist them in learning new skills.
We have a vacancy (an empty bed)	There is room for another person in our home.
Community Presence and Participation	
Six to 16 residents per facility	One to five persons in any one living situation
Large facilities located mainly in fringe and transitional neighborhood, to minimize community opposition	Small homes, apartments located in positively valued neighborhoods
Transportation provided almost totally by "special" means, i.e. facility-owned vehicles, county program busses, etc	Maximum use, when possible, of generic transportation services
Emphasis on large group activities; everyone goes shopping, bowling, etc. at the same time	Emphasis on individual and small group activities with nonhandicapped person in typical settings
After program opens little effort is made to interact with neighbors and to portray clients as members of neighborhood	Staff systematically assist persons with disabilities in active community participation
Program Function	
A community-based facility designed to house a population of disabled clients	A place to live in the community, with appropriate supports and services
Clients receive a wide range of habilitative services. At the extreme the facility provides for all of the client's 24 hour program needs	Persons with disabilities are assisted in acquiring functional competencies related to their living situation (would not serve both day and residential program needs)
Emphasis on cleanliness, health concerns, client supervision, training and protection	Program guidelines attempt to balance need for supervision and protection with the disabled person's rights regarding "Dignity of Risk"
Many children live in facilities served by staff who work on shifts	If support of the natural family is not possible, children live in alternative family situations.
Decision Making	
Residents follow pre-existing facility rules developed solely by management	Everyone living in the home plays an active role, if possible, in developing and modifying the rules for home living
No authority conflicts, residents must follow the rules	Potential for authority conflict, i.e. how do residential providers protect the rights of disabled persons to make decisions while still fulfilling their contract obligations for service/supervision?
Staff allowed to violate many rules which apply to clients	House rules apply to everyone who lives or works there

Issues Specific to Persons with Special Needs

Can a home-centered strategy be applied to serving persons with special needs such as severe behavior problems, chronic medical problems, deafness/blindness, etc.? There are a number of programs, across the country, that have shown that small size is not a limitation and is in fact usually an asset. For example, small programs have been successful in meeting the needs of persons with severe behavior problems, e.g., Jay Nolan program in California, Project TEACCH in North Carolina. The Developmental Maximation Unit of the ENCOR Community Program in Nebraska has a long record of successfully serving profoundly handicapped children with chronic medical problems in a small community-based setting. Small programs have been necessary to develop the types of intensive and individualized programs necessary for persons with severe behavior problems.

SMALL SIZE
NOT
LIMITATION

Because of the small numbers of people needing such specialized services, these programs often serve a multi-county or regional catchment area. However, this multi-county orientation is not incompatible with a small, well-integrated service strategy.

WHERE THEY LIVE AND HOW TREATED

It is more difficult to apply the philosophy or basic attitude of a home-centered approach to persons with very special needs. It would probably be difficult for most people to think of four adults with profound handicaps and severe behavior problems as living in "their own home" and being supported by an intensive program of supervision and care. However, as was pointed out previously in the section on program principles, the human dignity and status of persons with severe disabilities probably depends more on where they live and how they are treated than on their own actions and competencies. A home-centered approach to serving persons with special needs should increase their status as valued community members.

ELDERLY

Another "special needs" group deserves specific attention—older persons with developmental disabilities. Some people have rationalized, in the name of normalization, the placement of older disabled citizens into nursing homes because this is a typical or "normal" response to the residential needs of older nondisabled citizens. We cannot be trapped into this type of statistical approach to the principle of normalization. A number of progressive service programs for older citizens, such as the Minneapolis Aging and Opportunity Center, have developed a wide array of support programs to assist persons in staying in the community and out of institutional settings. Such programs are much more cost efficient and more consistent with our basic principles. We should look to these programs for models for future development.

HISTORIC MIND SET

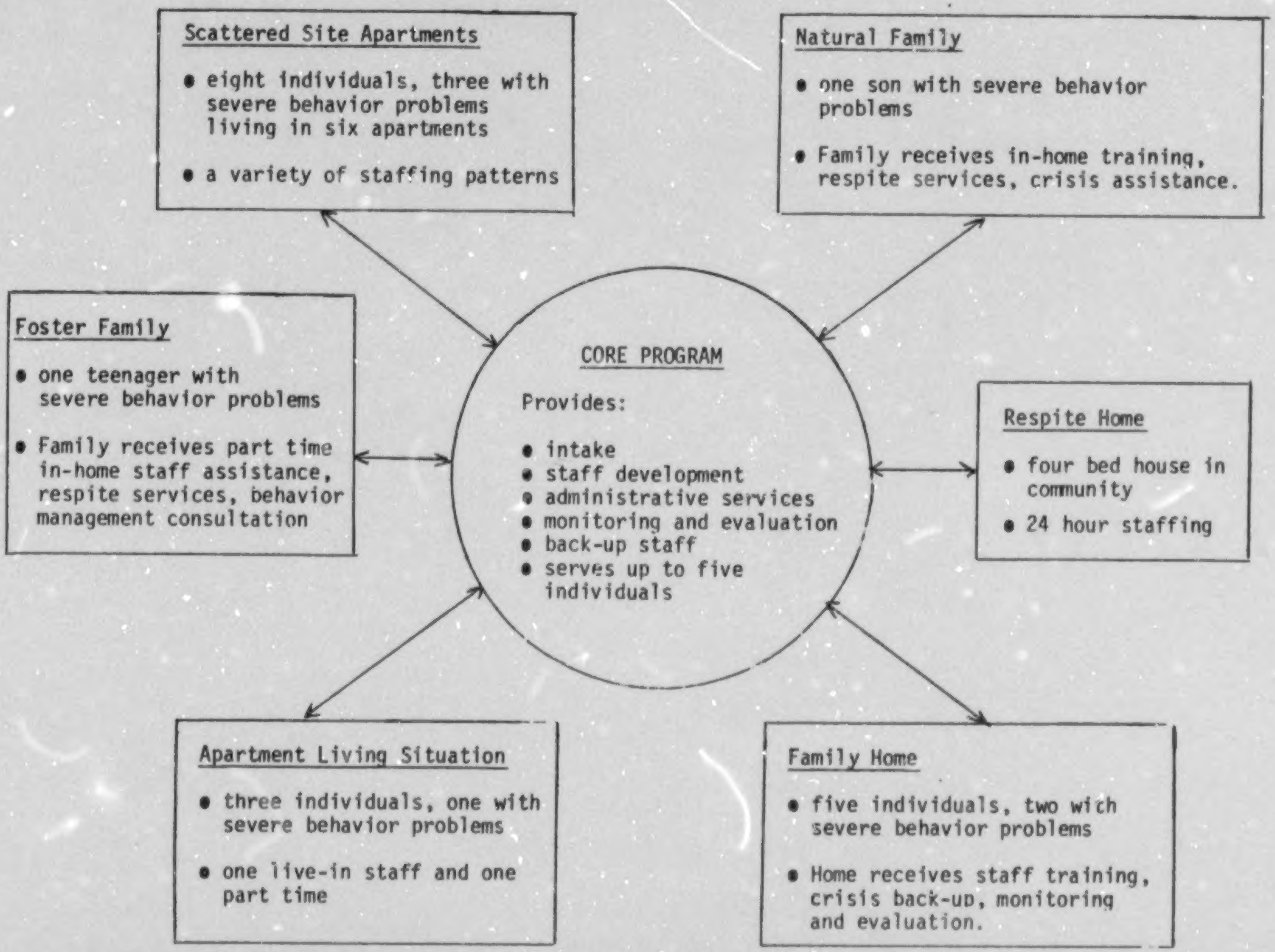
It should be emphasized that adoption of a home-centered approach does not require a neglect of the necessary training and supervisory aspects of a residential program. It does, however, require a break with the historical mind-set that special needs can only be met in very special (usually large and segregated) settings.

Residential Management Model

COORDINATE AND SUPPORT

The development of integrated residential options will require more efficient and effective management models at the local level to coordinate and support the various residential settings which will be necessary to meet the needs of persons with developmental disabilities. The diagram on the next page describes how one system (The Eastern Nebraska Community Office for Retardation - ENCOR) has successfully served persons with developmental disabilities in dispersed, integrated

Core-Cluster Services Strategy



Scattered Site Apartments

- eight individuals, three with severe behavior problems living in six apartments
- a variety of staffing patterns

Natural Family

- one son with severe behavior problems
- Family receives in-home training, respite services, crisis assistance.

Foster Family

- one teenager with severe behavior problems
- Family receives part time in-home staff assistance, respite services, behavior management consultation

CORE PROGRAM

Provides:

- intake
- staff development
- administrative services
- monitoring and evaluation
- back-up staff
- serves up to five individuals

Respite Home

- four bed house in community
- 24 hour staffing

Apartment Living Situation

- three individuals, one with severe behavior problems
- one live-in staff and one part time

Family Home

- five individuals, two with severe behavior problems
- Home receives staff training, crisis back-up, monitoring and evaluation.

settings. ENCOR utilized the core-cluster management model. Persons with developmental disabilities entered the system by first living in the CORE program and then quickly moved to one of a variety of alternative living arrangements (the cluster). They attempted to serve as few persons with disabilities as possible in any one living situation. The diagram provides a sample description of the variety of alternative living arrangements. The Core residential program provided the necessary technical assistance, training and support services. (Skarnulis, 1976)

There are a variety of other management models which could also be successful. Whatever model is chosen, it is clear that it must provide:

IMPORTANT COMPONENTS

- Comprehensive individual evaluation in realistic, normalized settings so that appropriate, alternative living arrangements can be selected or developed
- An adequate resource base to fund extra staff, special supports and services, etc.
- Flexibility in individual placement and evaluation
- Ongoing staff development
- Consumer involvement in all aspects of program planning, implementation and evaluation.

Transition

VARIETY OF CHANGES

PREPARE INDIVIDUALS TO LIVE IN COMMUNITY

REALISTIC DAY PROGRAMS

GENERIC RESOURCES

The development of a "home-centered" residential system for persons with developmental disabilities will require a variety of changes in other aspects of our service system. A change in one part of our service system will require changes in other areas, because service programs for persons with developmental disabilities are interdependent. For example, our school age and preschool programs—County Board and public schools—will need to more effectively and realistically prepare individuals to live in the community. Skill training in daily living must begin early to ensure that individuals will have the necessary skills to function most effectively and independently in a "home centered" environment. Vocational and day program services will need to be developed to complement the individual's living environment. The overall impact of a home-centered approach would be greatly increased if realistic work-oriented day programs were provided. It would not make sense to attempt to implement a residential program which focused on the development of age and culturally appropriate roles and activities and have the persons served in a day program which provides only "make work," devalued activities. In addition, an emphasis must be placed on ensuring that a variety of generic resources are available and coordinated through an effective

CASE COORDINATION

case coordination system. Service delivery at the local level must be integrated to ensure that the total needs of the individual can be met in a cohesive manner and that different community-based programs are not working at cross purposes.

NEED FOR CONCERTED EFFORT

The transition will necessitate a concerted effort to obtain family, professional and community acceptance of the "home-centered" concept. Without support from a variety of groups, implementation of such an approach is not likely to succeed. In part, successful implementation will depend upon the cooperative efforts of various service organizations, professionals, community leaders, consumer groups, and the general public. Public information and education programs, meaningful mechanisms to facilitate public discussion and input, and comprehensive pre- and inservice training programs will be needed.

LONG AND SHORT TERM PLANS

The transition to a "home-centered" system will be a lengthy process. We recognize that such a system of residential services cannot immediately be implemented. But if it is to be developed, we must begin to plan now. This paper recommends a direction which the state may utilize in developing its residential system for persons with developmental disabilities. If this direction is to be utilized both long and short term plans must be developed.

Presently, the state is under a great deal of pressure to reduce the population of developmental centers. However, this short term consideration cannot be viewed separately from our long-term goals.

COMMUNITY INSTITUTIONS

If large community institutions are not consistent with our long-term, home-centered plan, then it would be a serious mistake to continue the transinstitutionalization of persons from state institutions to community-based institutions. Tremendous sums of money would be necessary to establish a sufficient number of community institutional facilities—funds which would have to be diverted from the development of smaller more integrated alternatives. Thus, every effort should be made to restrict the development of new community institutions. In addition, local communities should begin to plan for the eventual phase-out of large community institutions presently in existence. The state will need to re-examine its present plan in terms of its long-term goals to ensure that these short-term plans contribute, as much as possible, to the attainment of our long-term goals. Although some compromises may be needed, it is imperative to remember that "long range planning does not deal with future decisions, but with the future of present decisions."

Residential Recommendations

GENERAL

- THERE SHOULD BE A COMPREHENSIVE, ADEQUATELY FUNDED, FAMILY SUPPORT SYSTEM.

- HOME OWNERSHIP PROGRAMS SHOULD EXIST WHICH ALLOW QUALIFIED PERSONS WITH DEVELOPMENTAL DISABILITIES TO PURCHASE THEIR OWN HOMES.

- THERE SHOULD BE SUPPORT SERVICES IN THE COMMUNITY TO ASSIST RESIDENTIAL PROGRAMS IN MEETING THE NEEDS OF INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES, INCLUDING THOSE SUPPORT SERVICES NEEDED TO MEET THE NEEDS OF PERSONS WITH SEVERE HANDICAPPING CONDITIONS AND BEHAVIOR PROBLEMS.

- INDIVIDUAL HABILITATION PLANS SHOULD BE JOINTLY DEVELOPED BY THE VARIOUS AGENCIES PROVIDING SERVICES TO PERSONS WITH DEVELOPMENTAL DISABILITIES.

- SHORT-TERM CRISIS INTERVENTION OPTIONS SHOULD EXIST FOR INDIVIDUALS EXPERIENCING ADJUSTMENT PROBLEMS AND THE RESPONSIBILITIES OF THE VARIOUS AGENCIES INVOLVED IN CRISIS SITUATIONS SHOULD BE CLEARLY DELINEATED.

- HOME-CENTERED RESIDENTIAL OPTIONS SHOULD BE AVAILABLE IN THE COMMUNITY FOR PERSONS WITH SPECIAL NEEDS, SUCH AS THOSE WITH MULTIPLE HANDICAPS, SEVERE BEHAVIOR PROBLEMS, CHRONIC MEDICAL PROBLEMS.

- THERE SHOULD BE AN ONGOING PROCESS FOR IDENTIFYING INDIVIDUALS WHO PREVIOUSLY HAVE BEEN INAPPROPRIATELY PLACED AND PLANS DEVELOPED TO ENSURE MOVEMENT TO MORE APPROPRIATE SETTINGS.

- APPROPRIATE CRITERIA FOR PLACING AN INDIVIDUAL FROM A DEVELOPMENTAL CENTER INTO A COMMUNITY RESIDENTIAL PROGRAM SHOULD INCLUDE THE FOLLOWING CRITERIA:

  - PLACEMENT BASED ON AN INDIVIDUAL'S NEEDS
  - PLACEMENT PROVIDES A BETTER ENVIRONMENT FOR THE INDIVIDUAL THAN DOES HIS/HER PRESENT LIVING ARRANGEMENT.
  - AVAILABILITY OF ADEQUATE COMMUNITY RESOURCES AND PROGRAMS
  - PLACEMENT IS IN SMALL COMMUNITY RESIDENTIAL PROGRAMS.

- THE INDIVIDUAL OR PARENT/GUARDIAN HAS HAD AN OPPORTUNITY TO PARTICIPATE AND IS SUPPORTED IN THE PLACEMENT DECISION.

- WORKABLE AGREEMENTS SHOULD EXIST WITH GENERIC SERVICE AGENCIES SUCH AS COUNTY CHILDREN'S SERVICES BOARDS, MENTAL HEALTH AGENCIES, ETC. RELATIVE TO SERVICES TO PERSONS WITH DEVELOPMENTAL DISABILITIES RESIDING IN THE COMMUNITY.

* * *

PLANNING

- THERE SHOULD BE A STATE PLAN FOR THE DEVELOPMENT OF A HOME-CENTERED RESIDENTIAL SERVICE SYSTEM IN OHIO.

- RESIDENTIAL PLANNING SHOULD BE AN INTEGRAL COMPONENT OF A COMMUNITY'S COMPREHENSIVE PLAN FOR SERVICES TO PERSONS WITH DEVELOPMENTAL DISABILITIES.

- THERE SHOULD BE BROAD-BASED COMMUNITY INVOLVEMENT IN RESIDENTIAL PLANNING AND DEVELOPMENT.

* * *

TRAINING/
TECHNICAL
ASSISTANCE

- A MANPOWER TRAINING PROGRAM(S) SHOULD EXIST TO INSURE THE AVAILABILITY OF TRAINED RESIDENTIAL PERSONNEL ESPECIALLY AT THE PARAPROFESSIONAL LEVEL.

- THERE SHOULD BE EXPANDED TRAINING OPTIONS FOR QMRP CERTIFICATION FOR RESIDENTIAL PERSONNEL.

- TECHNICAL ASSISTANCE AND CONSULATION SHOULD BE MADE AVAILABLE TO ASSIST IN PLANNING, DEVELOPING AND OPERATING RESIDENTIAL PROGRAMS FOR PERSONS WITH DEVELOPMENTAL DISABILITIES.

- THERE SHOULD BE ONGOING TRAINING TO INSURE UNIFORM INTERPRETATION OF RULES AND REGULATIONS GOVERNING RESIDENTIAL PROGRAMS.

* * *

FUNDING

- FUNDING FOR NEW RESIDENTIAL PROGRAMS SHOULD BE RESTRICTED TO RESIDENTIAL PROGRAMS SERVING EIGHT OR FEWER INDIVIDUALS AND SHOULD BE USED TO ENCOURAGE THE DEVELOPMENT OF EVEN SMALLER PROGRAMS.

- BARRIERS AND DISINCENTIVES RELATIVE TO THE UTILIZATION OF TITLE XIX ICF/MR FUNDING FOR SMALL HOME-CENTERED PROGRAMS SHOULD BE ELIMINATED.

- FUNDING FOR RESIDENTIAL SERVICES SHOULD BE ALLOCATED EQUITABLY TO SUPPORT INDIVIDUALS PRESENTLY LEAVING STATE INSTITUTIONS AND THOSE INDIVIDUALS CURRENTLY RESIDING IN THE COMMUNITY IN NEED OF RESIDENTIAL SERVICES.

- FUNDING FOR RESIDENTIAL SERVICES SHOULD BE BASED ON THE INDIVIDUAL'S NEEDS AND SERVICES RENDERED AND NOT ON THE TYPE OR SIZE OF THE FACILITY.

- FUNDING FOR RESIDENTIAL SERVICES SHOULD REFLECT PRESENT AND NOT HISTORIC COSTS.

- THERE SHOULD BE A FINANCIAL SUBSIDY PROGRAM WHICH REIMBURSES FAMILIES FOR THE COSTS OF RAISING THEIR DISABLED CHILD, INCLUDING SPECIAL DIETS, SPECIAL ADAPTIVE EQUIPMENT, MEDICATIONS, AND OTHER MATERIALS NEEDED TO PROVIDE AN APPROPRIATE GROWTH-CENTERED ENVIRONMENT WHICH CANNOT BE PAID FOR THROUGH EXISTING SOURCES.

- THE FEASIBILITY OF ESTABLISHING A STATEWIDE HOUSING AUTHORITY TO ASSIST LOCAL COMMUNITIES IN IDENTIFYING, DEVELOPING AND SECURING CAPITAL FUNDS BOTH PUBLIC AND PRIVATE FOR RESIDENTIAL DEVELOPMENT SHOULD BE EXPLORED. ITS MISSION SHOULD INCLUDE HOUSING FOR PERSONS WITH SPECIAL NEEDS.

* * *

MONITORING/
LICENSURE

- THERE SHOULD BE MINIMUM STANDARDS AND CRITERIA WHICH ADDRESS QUALITY OF LIFE AND NORMALIZATION PRINCIPLES IN LICENSURE RULES AND THE MONITORING/EVALUATION PROCESSES FOR RESIDENTIAL PROGRAMS.

- CONSUMERS AND CONSUMER ORGANIZATIONS SHOULD BE ENCOURAGED AND ASSISTED IN MONITORING THE SERVICE QUALITY OF RESIDENTIAL PROGRAMS AT THE LOCAL LEVEL.

- RESIDENTIAL PROVIDERS SHOULD BE ASSISTED AND ENCOURAGED TO DEVELOP INTERNAL EVALUATION MECHANISMS WHICH IDENTIFY THE STRENGTHS AND WEAKNESSES OF THEIR ADMINISTRATIVE PROCESS AND THE INDIVIDUAL'S PROGRAM.

- AN APPROPRIATE AND EFFICIENT EXTERNAL MONITORING SYSTEM SHOULD BE ESTABLISHED WHICH INCLUDES MEASURES TO ASSIST RESIDENTIAL PROVIDERS IN RECTIFYING IDENTIFIED WEAKNESSES.

- THERE SHOULD BE LICENSURE RULES WHICH PERMIT AND ENCOURAGE THE DEVELOPMENT OF SMALL RESIDENTIAL PROGRAMS, SEMI-INDEPENDENT AND INDEPENDENT LIVING OPTIONS.

- THERE SHOULD BE MINIMUM QUALIFICATIONS FOR RESIDENTIAL OPERATORS AND THEIR RESPONSIBILITIES SHOULD BE CLEARLY DELINEATED.

- RULES AND REGULATIONS GOVERNING RESIDENTIAL PROGRAMS SHOULD PERMIT FLEXIBILITY REGARDING THE LEVEL OF SUPERVISION AND PROGRAMMING, APPROPRIATE TO MEET AN INDIVIDUAL'S NEEDS. (CURRENTLY REGULATIONS "FORCE" MORE STRUCTURE AND SERVICES THAN ARE NEEDED FOR SOME PERSONS, WHILE OTHER PERSONS WITH SEVERE NEEDS CANNOT BE SERVED.)

- THE VARIOUS RESPONSIBILITIES AND PROCESSES FOR LICENSURE SHOULD BE CONSOLIDATED AND CLARIFIED.

APPENDIX A

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OHIO DEVELOPMENTAL DISABILITIES PLANNING COUNCIL

Manpower Training Task Force

Implementation Plan Task Group Report

THIS PLAN HAS BEEN SUBMITTED BY:

Sandra Perkins
Denis W. Stoddard
Beverly Johnson

OHIO DEVELOPMENTAL DISABILITIES PLANNING COUNCIL

MANPOWER TRAINING TASK FORCE IMPLEMENTATION PLAN TASK GROUP REPORT

September 2, 1982 (Amended January 28, 1983)

Background and Purpose:

During the July 8, 1982, meeting of the Manpower Training Task Force, one of the three year objectives and two of the plan year objectives were reviewed. Also at this meeting, some model guidelines having to do with quality manpower training and development on three different conceptual levels were presented and discussed. Out of the discussion that followed, it was decided by the members of the Task Force that an implementation plan task group be formed. This group was given the assignment of coming up with some initial suggested tasks for the Manpower Task Force to perform. These were to be tasks that would help Council reach some of its objectives related to Manpower Training. It is thus intended that this report serve as a "review-and-chew" document enabling the Task Force to identify some of its courses of action to be recommended to Council for approval and support.

Overview:

In order to keep this report somewhat complete and coherent, a brief explanation of the material and concepts presented at the July 8 Task Force meeting will be presented here.

Further explanation will then be given along with basic task recommendations. Examples of relevant kinds of resource materials are given in the attachments.[1]

The following is the Manpower Training Task Force's three year objective that was discussed:

> By September 30, 1982, relevant systemic manpower training programs, including instructional materials, will be developed and implemented on a collaborative basis by major state agencies represented on Council.

The two plan or current year objectives discussed were:

> The ODMR/DD Staff Development Plan to address manpower training issues for both maintenance and systems level impact will have been implemented by ODMR/DD.
>
> Council and committees will consistently address DD related manpower training needs which will be reflected in the State Plan for Developmental Disabilities.

The three year objective indicates that "systemic manpower training programs" will be developed. The first plan year objective also states that the ODMR/DD Staff Development Plan will have "systems level impact". The question arises as to the meaning of "systemic manpower training programs" and what must be done to foster quality training at this level. The following outline describes three conceptual levels at which quality manpower training and development can take place.

QUALITY MANPOWER TRAINING & DEVELOPMENT ON 3 LEVELS

I. Knowledge & Skills Training

Goal: Train individual(s) in knowledge and/or skills

II. Systematic Manpower Training

Goal: "I" plus set up an effective and efficient system for training individuals now and in the future

III. Systemic Manpower Training

Goal: "I" & "II" plus provide consultation in how results of training can be applied to improve the service delivery system; i.e., to help an organization reach its goals.

Providing quality training on Level I means doing all those things which result in individuals being trained well. This level of training does not deal as much with what people do with the knowledge and skills they acquire. It mainly just focuses on their being trained well in what it is perceived they need to know or be able to do.

Training at Level II is still concerned with how well people are trained, but also focuses on efficiency and how people are going to get trained in the future. Are there organized plans for getting everyone trained in the knowledge and skills they need? Collaborating and eliminating inefficiency and duplication in training efforts would be a typical concern here. Still what people do with the knowledge and skills acquired is left open to question. At Level II people are getting well trained, and it is being done in an organized (systematic) and efficient manner.

Training at Level III, while meeting the same standards as Level I and II, also deals with what people do with what they acquire. Here questions are asked like how can the new knowledge and skills best be applied. When applied, how will this training help the organization reach its goals; i.e., relate to systemic concerns. What plans are there to see that the training is applied for the purpose intended.

Understandably, at Level III a much greater involvement with administration takes place. Here the manpower development specialist acts as a consultant to the administrator, the objective is to use the specialist's knowledge and expertise to help the organization reach its goals and objectives.

This will typically occur in key administrative process areas, such as setting new long-term organizational goals, developing corresponding action plans and designing new or more goal oriented programs, all made possible by newly acquired staff competencies. The point is that manpower training should make a difference in personal and organizational performance at meeting the needs of the people being served. If it doesn't, how can the time, costs, and energies for doing it be justified. If manpower training is done well (Level I), as efficiently as possible (Level II), and can and does make a difference in meeting the needs and improving the quality of life of the people being served (Level III), then it will be serving its optimum purpose.

It should be emphasized that although Level III is optimum, it cannot occur easily without Levels I and II being accomplished. This is apparent in an article published in Training/HRD, January 1981, titled "Why Training Fails". Attachment #1 diagrams the 11 reasons for failure given in terms of the three levels of training.[1]

Recommended Tasks for the Task Force:

The implementation plan task group recommends two basic courses of action:

1. The Manpower Training Task Force should develop useful tools, guidelines, instructional materials, and resources that can help administrators and trainers implement quality Manpower Training and Development on all three levels of the Manpower Training Task Force Model.
2. The Manpower Training Task Force should disseminate these tools, information, materials in ways that will maximize their use by administrators and trainers for the purposes intended.

In terms of the basic kinds of tools or instructional materials that need to be used or further developed, the following items are given as examples:

Level I Training:

a. Instruments for training evaluation:
    1. Curriculum Evaluation Checklist (see Attachment #2).[1]
    2. Training Evaluation Checklist (see Attachment #3).[1]
    3. Additional contributions from Task Force members.

b. Trainer Resource Materials (see Attachment #4)[1]

1. Training Formats, Devices, and Skills List
2. Climate Setting Checklist
3. Group Decision Making Guide Sheet
4. Feedback Loop Guide Sheet
5. Workshop Checklist
6. Additional Materials from Task Force Members

c. Adult Education References (see Attachment #5)[1]

Level II Training: (There is some over-lap between Level II and Level III concerns in the referenced materials)

a. Manpower Development Checklist dealing specifically with Level II concerns (e.g., duplication, cost efficiency, future training plans, etc.) - for use by administrators and trainers.

b. Training Needs Assessment and Planning Materials (see Attachment #6)[1]

1. Defining the purpose of the needs assessment
2. A model for needs assessment
3. Training flowchart
4. Needs assessment objectives
5. Setting training priorities
6. Steps in the training decision process
7. A systematic approach for assessing training needs
8. The systems approach to training

c. Research, report, and give adaptive recommendations regarding ways in which other states, departments, and organizations, and members of the Task Force have dealt effectively with Level II concerns.

Level III Training: (See Attachment #6)[1]

a. Manpower Development Checklist and other instructional materials dealing specifically with Level III concerns - for use by Administrators and Trainers (see Attachment #7).[1]

b. Position paper dealing with the issues identified in the three level model.

c. Research, report, and give adaptive recommendations regarding ways in which other states, departments, and organizations, and members of the Task Force have dealt effectively with Level III concerns.

For the second recommendation relating to getting the materials disseminated and used, the kinds of activities suggested are:

1. Orientation presentations and/or training sessions for:
    a. State DD Council and related committees and personnel.
    b. DMR/DD Central Office Staff.
    c. DMR/DD Regional Office Staff and related Regional Manpower Development bodies.
    d. Relevant Manpower Development bodies or groups in other Ohio state departments, as invited.
    e. County agency staff.
    f. Other professionals serving DD population.
2. Explore the efficient and effective mechanisms, formats, conferences, gatherings, etc., for dissemination and implementation purposes.
3. Provide consultation to top administration in the various organizational bodies identified to facilitate the most productive use of the materials developed in terms of each organization's systemic goals.

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[1] Attachments available upon request

SECTION 5
GOALS, OBJECTIVES AND FUNDING

What are the State's Plan Year Objectives ?
Priority Listing and Summary of 1984-86 DD State Plan Activities
Plan Year Objectives
Contingency Plan
Summary of Proposed Developmental Disabilities Expenditures
Application for Sub-Grantees

SECTION 5: GOALS, OBJECTIVES AND FUNDING

5.1 What are the State's Plan Year Objectives?

PREVENTION

Goal 1 To lower the incidence of developmental disabilities through better utilization of existing services and knowledge.

1.1 By September 30, 1986, continuing education programs on the prevention of developmental disabilities for professionals in agencies serving rural areas of Ohio will have been developed and implemented, and videotape(s) on prevention of and methods to reduce the incidence of developmental disabilities will have been developed and made available to health professionals in all areas of the state.

1.1.1 By September 30, 1984, continuing education programs on prevention of developmental disabilities will have been developed and implementation of the programs will have begun in one or more regions of Ohio through an interagency collaborative effort between the University Affiliated Facility (UAF), Area Health Education Center Videotape(s) on prevention and ways to reduce the incidence of developmental disabilities will also have been developed and plans for dissemination of the videotape(s) to health professionals throughout Ohio, as well as in the region(s) will have been completed.

1.4 By September 30, 1986, public awareness activities will have been undertaken to increase the awareness of the general public, particularly women of child bearing age and pregnant women, regarding prevention of developmental disabilities.

1.4.1 By September 30, 1986, Ohio's pregnant women and women of child bearing age, especially low-income and minority women, will have been made aware of the risks of alcohol consumption during pregnancy.

1.5 By September 30, 1986, Ohio's elementary and secondary schools will have been encouraged to incorporate content on awareness and prevention of developmental disabilities into their curricula.

1.5.1 By September 30, 1984, school children throughout Ohio will have the opportunity to learn about disabilities through the "Kids on the Block", a group of disabled and non-disabled puppets designed for use in classrooms with follow-up activities for teachers.

1.5.2 By September 30, 1984, the Child Development Committee will have reviewed existing curricula aimed at teaching awareness and prevention of developmental disabilities, and the Committee will have explored strategies for introducing a recommended curriculum into Ohio's elementary and secondary schools.

1.6 By September 30, 1986, personnel in family planning programs in Ohio will have been provided training on the topic of prevention of developmental disabilities.

1.6.1 By September 30, 1984, staff of family planning programs in Ohio will have been provided training by the Ohio Department of Health, Genetics Services Network training staff on the topics of prevention of developmental disabilities and methods of reducing the incidence of developmental disabilities.

1.7 By September 30, 1986, personnel in agencies that serve children with developmental disabilities will have been provided the opportunity to attend regular, periodic training on the topic of child abuse and neglect.

1.7.1 By September 30, 1984, key policy makers in the Department of Mental Retardation and Developmental Disabilities and the County Boards of MR/DD Superintendents' Association will have been approached regarding the need to provide training on the topic of child abuse and neglect to staff in local programs and institutions; contact will have been made with the Ohio Department of Public Welfare (Children's Protective Services Unit) regarding its child abuse training program; and a cooperative effort between the two agencies will have been promoted and will have resulted in a specific interagency plan to ensure that staff in agencies which serve developmentally disabled children receive training on the topic of child abuse and neglect.

1.8 By September 30, 1986, genetic and perinatal services in Ohio will have continued to exist at a level not below that provided for in the 1982 budget.

1.8.1 By September 30, 1984, the Genetic Services Network and the Perinatal Regionalization Program will have continued operating at a level not below the 1982 budget, despite the generally unfavorable economic situation and potential budget cuts in many human service programs.

1.9 By September 30, 1986, outreach methods to increase the numbers of women seeking prenatal care during the first trimester will have been explored, and selected methods will have been further addressed by the Child Development Committee.

1.9.1 By September 30, 1984, the Child Development Committee will have reviewed the various innovative outreach strategies being developed by selected doctoral candidates from the OSU Public Administration graduate program, which is addressing methods whereby the Ohio Department of Health's prenatal care projects can have a greater outreach impact so that more pregnant women seek prenatal care during the first trimester of their pregnancies.

EARLY INTERVENTION

Goal 2 To ameliorate the effects of developmental disabilities by ensuring that all children in Ohio have access to early identification and appropriate intervention services as needed.

2.1 By September 30, 1984, there will be developed and implemented projects which demonstrate innovative solutions to the problem of involving parents of 0 through 4 year old children with developmental disabilities, in their child's program of treatment or education.

2.1.1 By September 30, 1984, the model project(s) which demonstrate mechanisms to participate in their child's infant stimulation, early intervention, treatment or other appropriate programs will have:

- continued to implement effective strategies which promote parental participation and will have explored, as appropriate, additional strategies
- worked collaboratively, through regular meetings of the project directors, to develop a composite model program plan for parental involvement, using the most effective components of each project
- collaboratively planned and implemented methods for dissemination of the individual and the composite designs
- separately completed program evaluations of their model projects
- separately and collaboratively developed and implemented strategies for locating external funding and securing internal agency commitment to continue their parent education and involvement activities
- provided consultation and technical assistance to the grantee responsible for the State Plan activity, "Training Parents and Professionals"

2.2 By September 30, 1986, legislation for a strong, non-permissive mandate, with the commensurate level of appropriation, for the expansion of ongoing identification, location and evaluation of all children suspected of being handicapped, and the provision of comprehensive services for all developmentally delayed children ages 0 through 4 in the State, will have been drafted.

2.2.1 By September 30, 1984, parent groups, state and federal legislators and other appropriate public officials will have been made aware of:

- the current status of legislation regarding early childhood education
- the importance of early intervention for handicapped children
- the cost effectiveness of early intervention for handicapped children
- the obvious gap between mandated identification, location and evaluation of all handicapped children below the age of 21 and the permissive provision of educational services for handicapped children below age 5 years

- the gap between the current fragmentation of the service delivery system and a model system of comprehensive, coordinated early intervention services to be developed under the State Plan Activity, "Establishing a Model System of Comprehensive, Coordinated Early Intervention Services."

2.2.2 By September 30, 1984, resource materials will have been located and/or developed to increase public and professional awareness of the value and cost-effectiveness of early intervention services, and plans will have been finalized for field testing and disseminating the products.

2.3 By September 30, 1986, a comprehensive, coordinated system of early intervention services, including a centralized referral mechanism, will have been designed for young children with or at risk of developmental delays/disabilities or other handicapping conditions.

2.3.1 By September 30, 1984, a comprehensive, coordinated system of early intervention services feasible for implementation in Ohio will have been designed. During the second and third plan years, revisions of Federal and State laws, regulations and rules will have been made wherever possible through coordination of efforts with the MR/DD Legislative Coalition and piloting of specific components at local or state levels will occur. By the end of the third plan year, the model system will be ready for implementation.

2.4 By September 30, 1986, the expertise, data and experiences from three projects funded by the DD Council to develop and implement model systems of early identification, referral and follow-up for developmentally disabled or "at risk" newborns and young children will have been used to increase the potential for successful accomplishment of the following State Plan Activities:

- Drafting legislation for early identification, evaluation and intervention
- Increasing public and professional awareness of value of early intervention
- Establishing a model system of comprehensive, coordinated early identification and intervention services
- Developing a system of ongoing program evaluation
- Training parents and professionals

2.4.1 By September 30, 1984, the awareness of leaders in the field on developmental disabilities in Ohio about issues involved in the early identification of children with developmental disabilities or at risk of having developmental disabilities will have been increased and the Early Intervention Task Force will have received information from local areas about state level changes needed to positively impact early identification and intervention efforts.

2.5 By September, 1986, data will exist in Ohio regarding the effectiveness and cost efficiency of early intervention programs for chilren with developmental disabilities.

2.5.1 By September, 1984, model(s) of program evaluation which will examine effectiveness and cost efficiency will have been reviewed and selected and plans completed for the adoption of selected model(s) by major systems offering early intervention programs in Ohio.

During the second plan year, model(s) of program evaluation selected by the Early Intervention Task Force will be adopted by the systems and implementation will begin. During the third plan year, evaluation will provide evidence about whether or not improvement is shown in the quantity, quality and comprehensiveness of service and consumer satisfaction within early intervention programs having implemented the model(s).

2.6 By September 30, 1986, training will have been made available to parents of children ages 0-4 with developmental delays to enable them to expand their capabilities to successfully access and maintain appropriate comprehensive services for their children and to appropriate professionals so they will understand and support the concept of parents being able to successfully access and maintain appropriate comprehensive services for their children.

2.6.1 By September 30, 1984, a training program which will be accessible to parents of children ages 0-4, and which teaches them to successfully access and maintain appropriate comprehensive services for their children and also teaches professionals who are directly involved in IEP and IHP development to support this concept and sensitizes them to parent needs, will have been planned and begun by a currently existing parent group, which will interface with parent groups throughout the state in order to make the training responsible to local needs/capabilities in each area.

During the second plan year, in addition to providing training, a conference will be planned to present to policy makers information regarding the concept, goals, curricula and methodologies, and outcomes of the training in order to attempt to have the training become incorporated into ongoing agency training programs. During the third plan year, training will continue and the conference will be held.

ALTERNATIVE COMMUNITY LIVING ARRANGEMENTS

Goal 3 To enable persons with developmental disabilities to live in the least restrictive environment, existing state and federal resources will be strengthened and the development of new resources will be stimulated.

3.1 By September 30, 1986, the Regional Center for Adaptive Equipment, Montgomery County, will be self sustaining and a replication of this Center will have been initiated in another area of Ohio.

3.3.1 The Regional Center for Adaptive Equipment, Montgomery County, will continue to exist for the design, fabrication and provision of adaptive equipment not commercially available.

3.2 By September 30, 1986, comprehensive fiscal and programmatic plans will exist which describe all federal, state and local components necessary for the development of a system of semi-independent/independent living programs in selected areas.

3.2.1 Comprehensive fiscal and programmatic plans which describe all federal, state and local components necessary for the development of semi-independent/independent living programs will have been designed to ensure their implementation in one rural and one urban area.

3.2.2 A comprehensive plan will have been developed and approved by the Ohio Department of Mental Retardation and Developmental Disabilities (ODMR/DD) for analyzing the data gathered by the recipients of grants numbered 84-17 to determine rule, policy and procedure changes necessary to the implementation of a system of semi-independent/independent living programs for people with developmental disabilities.

3.3 By September 30, 1986, a report will exist which describes a quality service/brokerage model for the provision of comprehensive family support and how the information from the model can be used to ensure the permanent existence of a family support system in Ohio.

3.3.1 A quality service/brokerage model for the provision of comprehensive family support will have been designed and implementation of the model will have been initiated in a rural area and an urban area.

3.3a By September 30, 1986, a permanent statewide system will exist for the provision of comprehensive family support and case coordination to include accessing specialized and generic services.

3.3a.1 A preliminary statewide system will have been designed and state level strategies developed by the Ohio Department of Mental Retardation and Developmental Disabilities (ODMR/DD) to ensure the provision of comprehensive family support including accessing generic and specialized services.

3.4 By September 30, 1986, a permanent source of funding will exist for the provision of respite and other family resources and administrative and programmatic guidelines and program development will reflect the philosophy of respite, and other family resources service provision as supported by the Developmental Disabilities Planning Council.

3.4.1 Council will support the Family Resources Program.

3.4.2 By September 30, 1985, the Position Paper - "Respite Services as a Component of Comprehensive Family Support" will have been printed and disseminated to a wide variety of policy makers and existing and potential service providers.

3.5 By September 30, 1986, plans consistent with the principle of normalization, will have been developed and implemented which articulate the elements and processes necessary for accessing all generic and specialized services for persons with developmental disabilities needing such services and which document services not available.

3.5.1 Issues will have been examined and strategies will have been designed which will contribute to the development of policies, procedures and resources which are committed to adoptive placement for all eligible children with developmental disabilities in Ohio.

Goal 4 To enable persons with developmental disabilities to live in the least restrictive environment and to enhance services to persons with developmental disabilities who have been and are being released under Ohio's Department of Mental Retardation/Developmental Disabilities Deinstitutionalization effort.

4.2 By September 30, 1986, major written recommendations which resulted from the efforts of the Deinstitutionalization Task Force will have been implemented in Ohio.

4.2.1 Action Plans will have been designed that target the most critical issues related to the provision of services for persons with developmental disabilities as documented in the Deinstitutionalization Task Force Report and where appropriate and feasible, implementation of Task Force Report recommendations will have commenced.

Goal 5 To ensure that the service needs of persons with developmental disabilities and related special needs (such as severe behavior problems and aging), are recognized and provided for at both state and local levels.

5.1 A comprehensive and self sustaining training system will exist to meet the needs of individuals who serve persons with developmental disabilities and related severe behavior problems.

5.1.1 An expert development and implementation team will have been established to provide for the training of a minimum of 12 staff trainers, to develop a staff training program and to conduct inservice orientations for persons serving individuals with developmental disabilities and related severe behavior problems.

5.2 By September 30, 1986, the Mental Retardation and Developmental Disabilities and Aging Committee of the Northeastern Ohio Consortium in Geriatric Medicine and Gerontology will be replicated in 3/4 areas of Ohio and a permanent mechanism will exist to provide for the ongoing training needs of staff from both service areas (MR/DD and Aging) who serve older adults with MR/DD.

5.2.1 Based on information provided through the development of a research monograph, inservice training modules will have been developed and competency based training will have occurred in five areas of the state for staff in agencies who provide services for older adults with MR/DD.

Materials and plans will exist which provide for the replication of the Mental Retardation/Developmental Disabilities and Aging Committee and for a permanent mechanism to provide ongoing training for staff who serve older adults with MR/DD.

5.3 By September 30, 1986, a mechanism will exist to ensure that persons with developmental disabilities including older adults, have access to appropriate services and programs conducted under the auspices of the Ohio Department of Public Welfare, Pre-Admission Screening System (PASSPORT) and other related programs of the Ohio Long Term Care Council, including the Ohio Commission on Aging.

5.3.2 Persons with developmental disabilities who seek nursing home admission, other than ICF/MR, will have been appropriately screened and will have received community services through the implementation of the Pre-Admission Screening System (PASSPORT).

Written information will exist which describes the extent to which services and programs funded by the Older Americans Act under the auspices of the Ohio Commission on Aging can be appropriately accessed by older adults with developmental disabilities and selected adults will have received such services.

MANPOWER TRAINING

Goal 6 To improve the quality of service provided to persons with developmental disabilities living in Ohio by identifying and providing for the ongoing educational needs, including skills/knowledge in systemic training and systemic training approaches, of professionals and paraprofessionals who work with those individuals.

6.1 A system for state and local interagency coordination of systemic and maintenance level manpower training programs will have been designed and implemented.

6.1.1 The Ohio Developmental Disabilities Planning Council (ODDPC), Committees and major state agencies represented on Council will consistently address DD related manpower needs.

6.1.2 A resource will be established to (1) develop and disseminate systemic training (training which is done well, is being done in an efficient and organized manner and contributes to an organization reaching its goals) resources and concepts, (2) to assist in state level interagency manpower training endeavors of the ODDPC Manpower Training Task Force and (3) to provide consultation in the establishment of multi-county, interagency training consortia.

6.1.3 Multi-county, interagency training consortia will have been established or expanded in up to four different geographic areas of Ohio.

ADVOCACY

Goal 7 To strengthen the voice of persons with developmental disabilities in Ohio through support of advocacy efforts.

7.1 Collaborative efforts by state-level agencies and organizations concerned with services to persons with developmental disabilities to (1) analyze legislative and budgetary needs for developmental disabilities and (2) disseminate information on legislative, budgetary and advocacy activities will be organized and implemented.

7.1.1 Information sharing between individuals, organizations, and agencies concerned with services for persons with developmental disabilities will be coordinated and technical assistance and training for the purpose of systems advocacy will be provided.

Goal 8 To expand and improve services for persons with developmental disabilities by increasing public acceptance of persons with developmental disabilities and by increasing public awareness of the nature of developmental disabilities.

8.1 By September 30, 1986, annual plans for public awareness, with strategies for multi-year continuation, will be implemented.

8.1.1 Implementation of the plan for coordinating public awareness efforts across groups at state and county levels will continue and public awareness efforts will be coordinated by developing linkages among county and state agencies which serve persons with developmental disabilities.

Goal 9 Appropriate services will be available to all persons with developmental disabilities as defined by P.L. 95-602.

9.1 By September 30, 1986, a plan will have been developed which describes how state and local agencies will meet the needs of persons with developmental disabilities other than mental retardation and implementation of that plan will have begun.

9.1.1 Needs of persons with developmental disabilities other than mental retardation will be made known to the Department of Mental Retardation/ Developmental Disabilities, other state and local agencies, and the Ohio Legislature, so that planning for the provision of appropriate services and necessary resources can begin.

9.1.2 The Tourette Syndrome Association of Ohio will raise $13,200. toward a permanent support base and will provide current and updated needs assessment information to assist in the development of a plan to meet the needs of persons with developmental disabilities other than mental retardation.

CONTINGENCY PLAN

Goal 3 To enable people with developmental disabilities to live in the least restrictive environment, existing state and federal resources will be strengthened and the development of new resources will be stimulated.

3.5 By September 30, 1986, plans consistent with the principle of normalization, will have been developed and implemented which articulate the elements and processes necessary for accessing all generic and specialized services for persons with developmental disabilities needing such services and which document services not available.

3.5.2 A community team in both a rural and urban area will have designed and begun to implement a plan that will (1) assist generic agencies in modification/adaptation of their programs in order to effectively respond to persons with developmental disabilities and (2) ensure access to specialized services for persons with developmental disabilities.

Goal 1 To lower the incidence of developmental disabilities through better utilization of existing services and knowledge.

1.10 By September 30, 1986, training will have been provided to parents of adolescents with developmental disabilities to enable the parents to provide family life education to their children.

1.10.1 By September 30, 1984, there will have been developed and implemented a project which demonstrates, in urban and rural areas, effective strategies and techniques for teaching parents how to provide family life education to their adolescent children with developmental disabilities.

During the second and third plan years, training will continue and, in addition, the curriculum and information on the training methodologies will be disseminated to other agencies which serve adolescents who are developmentally disabled.

Goal 2 To ameliorate the effects of developmental disabilities by ensuring that all children in Ohio have access to early identification and appropriate intervention services as needed.

2.7 By September 30, 1986, community personnel involved in diagnosis, assessment and individualized program development for children under five with developmental delays or disabilities will have had access to training in interdisciplinary approaches to diagnosis and assessment.

2.7.1 By September 30, 1984, existing curricula and training methodologies will have been reviewed, the curriculum for this training will have been compiled, and the appropriate training programs to upgrade the skills of practicing professionals in interdisciplinary diagnosis and assessment will have begun.

PRIORITY LISTING AND SUMMARY OF 1984-86 DD STATE PLAN ACTIVITIES[1]

PRIORITY	ACTIVITY	FEDERAL RESOURCES	MECHANISM	PAGE
1 (84-30)	MR/DD Legislative Coalition *A collaborative effort between individuals, organizations and agencies concerned with services for persons with developmental disabilities in order to (1) analyze legislative and budgetary needs, (2) disseminate information and (3) coordinate systems advocacy.*	$168,000.	Allocation	163
2 (82-3)	Designing & Providing Adaptive Equipment *The establishment of a permanent regional center for the design, fabrication and provision of adaptive equipment not commercially available.*	$100,000.	Carry-over Grant	118
3 (82-24)	Demonstrating Model Parent Education Programs *Programs designed to identify the problems and innovative solutions for the involvement of families in their child's treatment or education program.*	$ 70,000.	Carry-over (4 grants)	93
4 (84-28)	Systemic & Interagency Manpower Training Resource *To ensure that state and local level interagency training efforts result in (1) Training which is done well, (2) is being done in an efficient and organized manner and (3) contributes to an organization reaching its goals (systemic training).*	$ 36,000.	Contract	157
5 (84-29)	Multi-County, Interagency Training Consortia *The establishment or expansion of multi-county, interagency training consortia in four geographic areas to foster systemic and coordinated training.*	$ 90,800.	Grant	160
6 (84-31)	Coordinated Public Awareness Campaign *To ensure state and local level coordination of public awareness efforts.*	$ 87,112.	Allocation	166
7 (84-17)	Designing Semi-Independent/Independent Living Programs *The identification of all fiscal and programmatic components necessary for the permanent existence of semi-independent/independent living programs in Ohio.*	$ 54,730.	Grant	120
8 (84-5)	Expansion of "Kids on the Block" Program *To expand the opportunity for school children in Ohio to learn about disabilities through the purchase of additional "Kids on the Block" puppets and the provision of a two-day puppeteer workshop.*	$ 64,000.	Allocation	81
9 (84-32)	Appropriate Services for Persons with DD Other than Mental Retardation *The compilation, analysis and dissemination of service needs data specific to persons with developmental disabilities other than mental retardation in order to develop an appropriate and effective plan to meet those needs.*	$ 49,975.	Grant	169

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[1] Includes only those activities which require Federal Funds

PRIORITY	ACTIVITY	FEDERAL RESOURCES	MECHANISM	PAGE
10 (84-33)	Expanding & Improving Services for Persons with Tourette Syndrome	$ 56,270.	Allocation	172
	To assist in the development of a plan to meet the service needs of persons with developmental disabilities other than mental retardation, through the analysis of needs and service impact data for persons with Tourette Syndrome.			
11 (84-18)	Comprehensive Family Support	$ 37,760.	Grant	126
	The development of quality service/brokerage models of comprehensive family support which will provide information to ensure the permanent existence of a family support system in Ohio.			
12 (84-18a)	Comprehensive Family Support/ Accessing Specialized and Generic Services.	$ 24,034.	Allocation	129
	The development of state level strategies to ensure the provision of comprehensive family support which includes accessing generic and specialized services.			
13 (84-20)	Printing & Dissemination of Family Support Position Paper	$ 5,000.	Contract	134
	An influencing activity to assist in the development of appropriate and comprehensive family support services through the printing and dissemination of the Family Support Position Paper.			
14 (84-11)	Obtaining Non-Permissive Mandate for Early Identification & Intervention	$ 32,000.	Contract	97
	The analysis of all pertinent information and the coordination of appropriate advocacy coalitions toward the initiation of legislation, with appropriation, for early identification and intervention services in Ohio.			
15 (84-19)	Family Resources Program Legislation	$ 42,562.	Contract	132
	To ensure the passage of appropriate Family Resources Program Legislation and the development of philosophically sound administrative rules and service programs.			
16 (84-1)	Prevention Continuing Education in Rural Areas	$ 125,000.	Grant	74
	An interagency collaborative effort to develop and implement permanent continuing education programs on the prevention of developmental disabilities for professionals in agencies serving rural areas of Ohio.			
17 (84-12)	Increasing Public and Professional Awareness of Value of Early Intervention	$ 25,000.	Grant	100
	To increase the awareness of professionals and new mothers about normal child development and the value of early intervention, through development and dissemination of brochures, videotapes and slide-tapes.			

PRIORITY	ACTIVITY	FEDERAL RESOURCES	MECHANISM	PAGE
18 (84-23)	Deinstitutionalization Task Force Report - Action Plan *The design of action plans that target the most critical issues related to the provision of services for persons with developmental disabilities as documented in the Deinstitutionalization Task Force Report and dissemination of the five position papers of the Task Force.*	$ 72,016.	Allocation	138
19 (84-4)	Public Awareness of Prevention *To reach pregnant women and women of child bearing age, especially low income and minority women, throughout the state and increase their awareness of the risks of alcohol consumption during pregnancy.*	$ 10,000.	Allocation	78
20 (84-24)	Development of a Training System for Persons Serving Individuals with DD and Related Severe Behavior Problems *The design and implementation of a statewide self-sustaining training system for the training of staff trainers serving individuals with developmental disabilities and related severe behavior problems.*	$ 157,000.	Grant	140
21 (84-13)	Model System of Early Intervention Services *The development of a model system of comprehensive, coordinated early intervention services for Ohio, through analysis of the current system and review of pertinent materials and data.*	$ 20,000.	Contract	103
22 (84-13a)	Establishing a Model System of Comprehensive, Coordinated Early Intervention Services *Fostering the continuation of local interagency collaboration committees in three areas of Ohio as part of the development of a model statewide system.*	$ 12,000.	Allocations	106
23 (84-25)	Dissemination/Replication of the Northeastern Ohio Consortium in Geriatric Medicine and Gerontology, MR/DD & Aging Committee *The dissemination and replication of an interagency (MR/DD & Aging) effort designed to impact the service delivery system for persons with MR/DD who are aging and aged.*	$ 67,500.	Allocation	148
24 (84-14)	Early Identification *Exploration of issues/barriers/gaps/existing and ideal services for early identification of infants and children who are at risk or developmentally disabled.*	$ 35,320.	Contract/ Allocation	108

PRIORITY		ACTIVITY	FEDERAL RESOURCES	MECHANISM	PAGE
25	(84-26)	Generic Community Services for Older Adults with Developmental Disabilities	$ 35,550.	Allocation	152
		Implementation of activities in order to ensure that older adults with developmental disabilities have access to appropriate services and programs conducted under the auspices of the Ohio Department of Public Welfare, Nursing Home Pre-Admission Screening System (PASSPORT) and those funded by the Older American's Act under the auspices of the Ohio Commission on Aging.			
26	(84-15)	Developing a System of Ongoing Program Evaluation	$ 30,000.	Contract	112
		The formulation and implementation of model(s) of program evaluation to examine the effectiveness and cost efficiency of early intervention programs in Ohio.			
27	(84-16)	Training Parents and Professionals to Access Services	$ 80,000.	Grant	115
		Development and statewide implementation of a training program by a parent group for parents and professionals on successfully accessing and maintaining comprehensive services.			
ACTIVITIES IN CONTINGENCY PLAN:					
28	(84-34)	Accessing Generic & Specialized Services	$ 60,000.	Grant	114
		The development and implementation of a plan that will (1) assist generic agencies in modification/adaptation of their programs in order to effectively respond to persons with developmental disabilities and (2) ensure access to specialized services for persons with developmental disabilities.			
29	(84-35)	Training Parents of Adolescents with Developmental Disabilities	$ 60,000.	Grant	177
		Provision of training to parents of adolescents with developmental disabilities to enable the parents to provide family life education to their adolescent children.			
30	(84-36)	Training in Inter-Disciplinary Approaches to Diagnosis and Assessment	$ 80,000.	Allocation	180
		Provision of on-site training for community personnel in inter-disciplinary approaches to diagnosis and assessment.			

TABLE 5-1: PLAN YEAR OBJECTIVES
Section 133(b)(2)(A)

TITLE (84-1) *Prevention Continuing Education in Rural Areas*

GOAL

1 To lower the incidence of developmental disabilities through better utilization of existing services and knowledge

Three Year Objective

1.1 By September 30, 1986, continuing education programs on the prevention of developmental disabilities for professionals in agencies serving rural areas of Ohio will have been developed and implemented, and videotape(s) on prevention of and methods to reduce the incidence of developmental disabilities will have been developed and made available to health professionals in all areas of the state.

Plan Year Objective

1.1.1 By September 30, 1984, continuing education programs on prevention of developmental disabilities will have been developed and implementation of the programs will have begun in one or more regions of Ohio through an interagency collaborative effort between the University Affiliated Facility (UAF), Area Health Education Center (AHEC), and the Ohio Cooperative Extension Service in the region(s). Videotape(s) on prevention and ways to reduce the incidence of developmental disabilities will also have been developed and plans for dissemination of the videotapes to health professionals throughout Ohio, as well as in the region(s), will have been completed.

Strategy

Funds will be made available for a period of three years for a coordinated approach to the provision of continuing education programs on prevention to professionals in rural areas of Ohio. During the first year the AHEC, UAF and Cooperative Extension Service in one or more regions of Ohio will develop and begin implementation of the continuing education programs for professionals in the three core agencies and other agencies in the rural areas of the region(s). During the first year the responsible agents will develop videotape(s) for health professionals on prevention of developmental disabilities and methods of reducing the incidence of developmental disabilities and plans for dissemination of the videotape(s) throughout the State, in urban and rural areas, will be finalized.

During the second and third plan years the responsible agents will meet with and provide technical assistance to the three core agencies in all areas of the State to ensure replication of the coordination effort in all areas of the State and to effect permanent systemic change resulting in ongoing continuing education efforts on prevention in all rural areas of Ohio. The responsible agents will also disseminate the videotape(s) throughout the State during the second and third years, making them available to health professionals in both rural and urban areas.

Responsible Agent(s)

The University Affiliated Facility, Area Health Education Center and Cooperative Extension Service in one or more regions of Ohio

Target Population(s)

Staff of the UAF, AHEC and Cooperative Extension Service
Health Professionals
General Public

Anticipated Activities

a. The lead agency will ensure coordination of the AHEC, UAF and Cooperative Extension Service which serve the geographic area involved and will convene meetings on a regular basis of the three agencies.

b. The three agencies will develop continuing education and training programs for staff of their own agencies, staff of public health agencies and other appropriate professionals to train them in the area of prevention of developmental disabilities.

c. The trainers will be knowledgeable in the area of prevention of developmental disabilities and skilled in adult education methods.

d. The continuing education programs will include components on how the professionals trained can utilize the acquired knowledge to work with their specific groups of rural populations; i.e., homemaker programs, 4-H programs, etc., to reduce the incidence of developmental disabilities.

e. The development of the videotapes will be based on need for production of new videotape(s), after a thorough search is conducted and existing videotape(s) purchased as appropriate.

f. Videotape(s) will cover at least the following topics: genetics, rubella immunity, prenatal care, drug and alcohol abuse, smoking, safety, nutrition, and maternal PKU.

g. An advisory board will be established to advise on the content of the videotape(s) and to approve the script and format before they are produced. Membership will include representatives from the Ohio Chapter of Pediatrics, The Ohio State Medical Association, the Ohio Hospital

Association, the DD Council Child Development Committee and Public Awareness Campaign.

h. The videotape(s) are to be:

   (1) shown on hospitals' television health education networks which provide Category 1 Continuing Education Credit, (2) used for continuing education programs through state and county medical associations and (3) included on agendas for health professionals' conferences.

i. The videotape(s) are to be produced in style and format which could be broadcast on public television, if possible, and this avenue of dissemination is to be thoroughly investigated and used if feasible.

j. Recommendations for further use of the videotape(s) are to be made.

k. The responsible agent(s) will develop specific action plans, including definite staff assignments, timelines and activities for ensuring that the continuing education effort is replicated statewide and that the training activities become a permanent part of the system.

l. The responsible agent(s) will establish linkage with the multi-county interagency training consortia (if in the geographic area), as implemented under the 1984-86 DD State Plan.

Outcome Indicators

a. Extent to which the three agencies coordinate their efforts to develop and implement continuing education programs on prevention of developmental disabilities

b. Number of health care professionals, staff of the AHEC and staff of the Ohio Extension Service trained

c. Evaluation of the continuing education by the participants

d. Results of pre and post-tests given to participants

e. Extent to which professionals utilize their increased awareness and knowledge of prevention of developmental disabilities with their clients

f. Extent to which the trainers are knowledgeable in the area of prevention of developmental disabilities and skilled in adult education methods

g. Extent to which plans are made for systemic implementation statewide

h. Extent to which existing videotape(s) are reviewed

i. Degree to which the videotape(s) thoroughly cover prevention of developmental disabilities

j. Extent to which hospitals and health care professionals accept and show the videotape(s) (second year)

k. Extent to which state and county medical associations use the videotape(s) for continuing education (second year)

l. Number of agendas of health professionals' conferences on which the videotape(s) are listed (second year)

Projected Plan Year Funding

	FFY 1984 (1st year)	FFY 1985 (2nd year)	FFY 1986 (3rd year)
Federal Funds:	$125,000.	$104,000.	$100,000.
Non-Federal Funds:	$ 41,667.	$ 34,667.	$ 33,333.
Total:	$166,667.	$138,667.	$133,333.

Priority Service Area Child Development:

Training of personnel to provide service in the area.

TITLE (84-4) *Public Awareness of Prevention**

GOAL

1 To lower the incidence of developmental disabilities through better utilization of existing services and knowledge

Three Year Objective

1.4 By September 30, 1986, public awareness activities will have been undertaken to increase the awareness of the general public, particularly women of child bearing age and pregnant women, regarding prevention of developmental disabilities.

Plan Year Objective

1.4.1 By September 30, 1984, Ohio's pregnant women and women of child bearing age, especially low-income and minority women, will have been made aware of the risks of alcohol consumption during pregnancy.

Strategy

Funds will be allocated to the Ohio Department of Health for a period of one year for the development and implementation of an awareness campaign about the hazards of alcohol use during pregnancy and for the provision of technical assistance to health professionals to increase their skills in assessment and counseling about alcohol use among pregnant women.

Responsible Agent(s)

Ohio Department of Health

Target Population(s)

General public, especially women of child-bearing age and pregnant women, with emphasis on low income and minority populations.

Anticipated Activities

a. Assess "state of the art" materials related to alcohol use during pregnancy and fetal alcohol syndrome. Acquire and/or develop public awareness materials, e.g., brochures, posters, radio/TV Spots.

b. Implement a public awareness campaign on the hazards of alcohol consumption during pregnancy.

c. Assist health professionals to improve assessment and counseling skills by providing technical assistance to 122 Bureau of Maternal and Child Health (BMCH) and Bureau of Alcohol Abuse and Alcoholism Recovery (BAAR) projects.

d. Establish an advisory committee to review and evaluate existing awareness and training materials. The committee shall include the Child Development Committee staff person and a representative of the Child Development Committee.

e. Develop a plan to distribute awareness materials statewide; focus on low income and minority populations.

f. Develop a means to ensure that public service announcements used in the campaign are broadcast regularly and, to the extent possible, at times for maximum viewing.

g. Maintain data on the distribution of awareness materials.

h. Make periodic reports to the Child Development Committee and submit materials to it for review prior to distribution.

Outcome Indicators

a. Extent of effort to search for existing materials

b. Extent to which advisory board is used to review materials

c. Extent to which the distribution plan targets low-income and minority populations

d. Extent to which public service announcements are monitored to insure their use

e. Number of materials distributed

f. Number of BMCH and BAAR projects implementing campaign on the local level

g. Extent to which number of professionals receiving technical assistance is documented

Projected Plan Year Funding

	FFY 1984 (1st Year)	FFY 1985 (2nd Year)	FFY 1986 (3rd Year)
Federal Funds:	$ 10,000.	To be determined	
Non-Federal Funds:	$ 3,333.		
Total:	$ 13,333.		

Priority Service Area   Child Development:

Activities to increase the capacity of institutions and agencies to provide services in the area.

*Text amended 12/83

TITLE (84-5) *Expanding the Availability of "Kids on the Block" in Ohio*

GOAL

1 To lower the incidence of developmental disabilities through better utilization of existing services and knowledge.

Three Year Objective

1.5 By September 30, 1986, Ohio's elementary and secondary schools will have been encouraged to incorporate content on awareness and prevention of developmental disabilities into their curricula.

Plan Year Objective

1.5.1 By September 30, 1984, school children throughout Ohio will have the opportunity to learn about disabilities through the "Kids on the Block", a group of disabled and non-disabled puppets designed for use in classrooms with follow-up activities for teachers.

Strategy

Funds will be allocated to the 16 Special Education Regional Resource Centers in Ohio to enable the 12 SERRC's which previously obtained Kit A of the KOB to purchase Kit B and two additional puppets of their choice; to enable the four remaining SERRC's to purchase Kit A; and to provide a two-day workshop for puppeteers from the 16 SERRC's which is offered by KOB, Inc.

Responsible Agent(s)

Ohio's Special Education Regional Resources Centers

Target Population(s)

School age children in Ohio

Anticipated Activities

a. Interested SERRC's will attend meeting(s) initiated by Council and DD Program Unit staff to exchange ideas about recruitment of puppeteers and promotion of the program.

b. All SERRC's receiving an allocation will participate in the two-day workshop for puppeteers.

c. SERRC's will collaboratively design a program to notify schools about the availability of the "Kids on the Block" and to encourage requests.

d. SERRC's, Council and DD Program Unit staff will collaboratively evaluate the effectiveness of the KOB Program.

Outcome Indicators

a. Number of SERRC's participating

b. Number of requests for the KOB received and filed

c. Quality of response from teachers, students and community groups to the KOB

Projected Plan Year Funding

	FFY 1984 (one year)
DD Program Funds:	$64,000.
Non-Federal Funds:	$21,333.
Total:	$85,333.

Priority Service Area Child Development:

Provision of services in the area.

TITLE (84-6) *Curriculum on Awareness and Prevention*

GOAL

1 To lower the incidence of developmental disabilities through better utilization of existing services and knowledge

Three Year Objective

1.5 By September 30, 1986, Ohio's elementary and secondary schools will have been encouraged to incorporate content on awareness and prevention of developmental disabilities into their curricula.

Plan Year Objective

1.5.2 By September 30, 1984, the Child Development Committee will have reviewed existing curricula aimed at teaching awareness and prevention of developmental disabilities, and the Committee will have explored strategies for introducing a recommended curriculum into Ohio's elementary and secondary schools.

Strategy

The Child Development Committee staff will: (1) review existing curricula which include content on awareness of developmental disabilities and ways to prevent the occurrence of developmental disabilities, such as rubella immunization, proper nutrition, early prenatal care, safety, etc.; (2) explore strategies for introducing such curricula in the public schools; and (3) report this information to the Child Development Committee which will develop a plan for introducing such curricula into the schools during the next two plan years.

Responsible Agent(s)

Child Development Committee
Child Development Committee Staff

Target Population(s)

Students in Ohio's elementary and secondary schools

Anticipated Activities

a. Child Development Committee staff will locate and review existing curricula.

b. Child Development Committee staff will explore with various schools ideas/strategies whereby the Committee could successfully introduce a recommended curriculum.

c. Child Development Committee staff will present the findings of this research to the Committee.

d. The Child Development Committee will determine whether to proceed to introduce a recommended curriculum into Ohio's schools and, if so, select strategies.

Outcome Indicators

a. Number of existing curricula located and reviewed by staff.

b. Thoroughness of report by staff to Child Development Committee on curricula and strategies for introducing curricula.

Projected Plan Year Funding

None

Priority Service Area   Child Development:

Activities to increase the capacity of institutions and agencies to provide services in the area.

TITLE (84-7) *Promoting Training of Family Planning Staff*

GOAL

1 To lower the incidence of developmental disabilities through better utilization of existing services and knowledge

Three Year Objective

1.6 By September 30, 1986, personnel in family planning programs in Ohio will have been provided training on the topic of prevention of developmental disabilities.

Plan Year Objective

1.6.1 By September 30, 1984, staff of family planning programs in Ohio will have been provided training by the Ohio Department of Health, Genetics Services Network training staff on the topics of prevention of developmental disabilities and methods of reducing the incidence of developmental disabilities.

Strategy

The Child Development Committee, through Council, will request that the Ohio Department of Health's Genetics Services Network training staff provide training programs for staff of family planning clinics in Ohio, using resources already available for such training.

Responsible Agent(s)

DD Council
Child Development Committee
Child Development Committee Staff
Ohio Department of Health
Genetics Services Network

Target Population(s)

Staff of family planning clinics

Anticipated Activities

Staff to Child Development Committee will prepare a letter to be forwarded to the Ohio Department of Health from Council with this request.

Outcome Indicators

Existence of a letter from Child Development Committee to the Ohio Department of Health.

Projected Plan Year Funding

None

Priority Service Area Child Development:

Training of personnel to provide services in the area.

TITLE (84-8) *Promoting Interagency Effort for Child Abuse Training*

GOAL

1 To lower the incidence of developmental disabilities through better utilization of existing services and knowledge

Three Year Objective

1.7 By September 30, 1986, personnel in agencies that serve children with developmental disabilities will have been provided the opportunity to attend regular, periodic training on the topic of child abuse and neglect.

Plan Year Objective

1.7.1 By September 30, 1984, key policy makers in the Department of Mental Retardation and Developmental Disabilities and the County Boards of MR/DD Superintendents' Association will have been approached regarding the need to provide training on the topic of child abuse and neglect to staff in local programs and institutions; contact will have been made with the Ohio Department of Public Welfare (Children's Protective Services Unit) regarding its child abuse training program; and a cooperative effort between the two agencies will have been promoted and will have resulted in a specific interagency plan to ensure that staff in agencies which serve developmentally disabled children receive training on the topic of child abuse and neglect.

Strategy

DD Council Staff will convene meetings of appropriate key policy makers of the Department of Mental Retardation and Developmental Disabilities, the Ohio Department of Public Welfare, and the Ohio 169 Board Superintendents' Association to promote a joint effort between the agencies for the provision of such training.

Responsible Agent(s)

Child Development Committee
Child Development Committee Staff

Target Population

Staff of agencies which serve children who are developmentally disabled.

Anticipated Activities

a. Committee members and staff will meet with key policy makers in the Ohio Department of Mental Retardation/Developmental Disabilities and the Ohio 169 Board Superintendents' Association to explore and encourage their interest in training staff in the area of child abuse.

b. Meetings will be facilitated between key personnel of Ohio Department of Mental Retardation/Developmental Disabilities, the Superintendents' Association and the Ohio Department of Public Welfare to develop an interagency agreement, formal or informal, for provision of training by the Children's Protective Services Unit of Ohio Department of Public Welfare for staff of DD agencies. This agreement should include the roles and responsibilities of each agency.

c. The DD Council's Manpower Training Task Force will be invited to participate in this effort.

Outcome Indicators

a. Extent to which key individuals on Ohio Department of Mental Retardation/Developmental Disabilities and the Ohio 169 Superintendents' Association become interested in seeing that Child Abuse training is provided to personnel in agencies that serve children with developmental disabilities.

b. Extent to which meetings are scheduled between Ohio Department of Mental Retardation/Developmental Disabilities, the County Boards of MR/DD Superintendents' Association, and Ohio Department of Public Welfare.

c. Existence of a letter to Manpower Training Task Force inviting it to participate in accomplishing this objective.

Projected Plan Year Funding

None

Priority Service Area Child Development:

Training of personnel to provide services in the state.

TITLE (84-9) *Monitoring State Funding of Genetics and Perinatal Programs*

GOAL

1 To lower the incidence of developmental disabilities through better utilization of existing services and knowledge

Three Year Objective

1.8 By September 30, 1986, genetic and perinatal services in Ohio will have continued to exist at a level not below that provided for in the 1982 budget.

Plan Year Objective

1.8.1 By September 30, 1984, the Genetic Services Network and the Perinatal Regionalization Program will have continued operating at a level not below the 1982 budget, despite the generally unfavorable economic situation and potential budget cuts in many human service programs.

Strategy

The Child Development Committee will request the Mental Retardation/Developmental Disabilities Legislative Coalition to advocate for continued funding of the Genetic Services Network and the Perinatal Regionalization Program by presenting factual information pertaining to the value and cost effectiveness of these programs to the state legislature.

Responsible Agent(s)

Ohio Department of Health
Developmental Disabilities Council
Child Development Committee
Mental Retardation/Developmental Disabilities Legislative Coalition
Child Development Committee Staff

Target Population(s)

Women of child-bearing age, pregnant women and newborns

Anticipated Activities

a. Developmental Disabilities Council staff, members of the Child Development Committee and staff of the Perinatal Regionalization Program and the Genetic Services Network will provide succinct information regarding the value and cost effectiveness of the Genetics Network and the Perinatal Program to the MR/DD Legislative Coalition and its staff.

b. The MR/DD Legislative Coalition staff will provide the information pertaining to the value and cost effectiveness of the perinatal and genetics programs to the Coalition's Consumer Advocacy Network and to key legislators, as needed, if budget cuts are anticipated.

Outcome Indicators

a. Degree to which DD Council staff, members of the Child Development Committee and staff of the Perinatal Regionalization Program and the Genetic Services Network provide succinct information to the MR/DD Legislative Coalition and its staff.

b. Degree to which the budgets are maintained at a level not below the 1982 budget.

Projected Plan for Funding

None

Priority Service Area Child Development:

Activities to increase the capacity of institutions and agencies to provide services in the area.

TITLE (84-10) *Prenatal Outreach Strategies*

GOAL

1 To lower the incidence of developmental disabilities through better utilization of existing services and knowledge

Three Year Objective

1.9 By September 30, 1986, outreach methods to increase the numbers of women seeking prenatal care during the first trimester will have been explored, and selected methods will have been further addressed by the Child Development Committee.

Plan Year Objective

1.9.1 By September 30, 1984, the Child Development Committee will have reviewed the various innovative outreach strategies being developed by selected doctoral candidates from the OSU Public Administration graduate program, which is addressing methods whereby the Ohio Department of Health's prenatal care projects can have a greater outreach impact so that more pregnant women seek prenatal care during the first trimester of their pregnancies.

Strategy

A small, short-term subcommittee of Child Development Committee members will be convened to review the innovative strategies for outreach being developed by selected OSU Public Administration doctoral candidates, and to select one or more of the strategies to be further developed.

Responsible Agent(s)

Child Development Committee
Child Development Committee Staff

Target Population(s)

High risk pregnant women

Anticipated Activities

a. The Child Development Committee will establish a small short-term subcommittee of Child Development Committee members to review the innovative strategies being developed by the group of OSU Public Administration doctoral candidates.

b. The subcommittee will select one or more of the strategies for implementation via the State Plan.

Outcome Indicators

a. Extent to which subcommittee members participate regularly.

b. Extent to which the innovative strategies are reviewed by the subcommittee.

Projected Plan Year Funding

None

Priority Service Area

Child Development:

Outreach to individuals for the provision of service.

TITLE (82-24) *Demonstrating Model Parent Education Program*

GOAL

2 To ameliorate the effects of developmental disabilities by ensuring that all children in Ohio have access to early identification and appropriate intervention services as needed.

Three Year Objective

2.1 By September 30, 1984, there will be developed and implemented projects which demonstrate innovative solutions to the problem of involving parents of 0 through 4 year old children with developmental disabilities, in their child's program of treatment or education.

Rationale for Model Projects

Child Development is one of two priorities for the Ohio Developmental Disabilities Planning Council for the planning cycle 1981 and 1984. Within the area of Child Development, the Council has focused on the preschool child, specifically, 0 through 4 years of age.

Infant stimulation and early intervention programs are primary vehicles through which preschool children with disabilities receive services. Because children in their earliest years are extremely receptive to stimulation, the child's parent is traditionally encouraged to participate in treatment or therapy in order to maximize at home the benefits offered by the service provider. Often there arise problems in obtaining parental involvement in the child's treatment or education program. The two different kinds of problems identified by the Child Development Committee as needing attention are described as follows:

a. the parent who cannot participate in his child's program due to an obstacle beyond his control, and

b. the parent who does not participate due to conscious or unconscious decisions that make participation a low priority, or based on a lack of understanding of the importance of participation.

The purpose of this three year project is to demonstrate a model solution to obtaining parent involvement in situations that fall under either example (a) or (b). The demonstration will include:

a. clarifying the problem

b. generating solutions

c. designing and testing dissemination of the model through workshops, checklists, an operating manual, brochures or video tapes, bibliographies or other products

Plan Year Objective

2.1.1 By September 30, 1984, the model project(s) which demonstrate a mechanism to enable and encourage parents of children with developmental disabilities to participate in their child's infant stimulation, early intervention, treatment or other appropriate programs will have:

- continued to implement effective strategies which promote parental participation and will have explored, as appropriate, additional strategies
- worked collaboratively, through regular meetings of the project directors, to develop a composite model program plan for parental involvement, using the most effective components of each project
- collaboratively planned and implemented methods for dissemination of the individual and the composite designs
- separately completed program evaluations of their model projects
- separately and collaboratively developed and implemented strategies for locating external funding and securing internal agency commitment to continue their parent education and involvement activites
- provided consultation and technical assistance to the grantee responsible for the State Plan activity, "Training Parents and Professionals"

Strategy

Based on monitoring and evaluation results which document successful accomplishment of grantee goals and objectives and their contribution toward the successful accomplishment of the objectives of the FFy 1983 State Plan Amendment, funds will be made available for the third year of this objective.

Responsible Agent(s)

Ohio State University - School of Social Work
Blanchard Valley Board of MR/DD and Bowling Green State University
Rehabilitation Services of North Central Ohio
Holmes County Board of MR/DD

Target Population(s)

Parents of 0 through 4 year old children with developmental disabilities who are non-participants in their children's infant stimulation or early intervention or other programs, where opportunities for such participation exist.

Anticipated Activities

a. Continue to explore the best mix of activities/intervention which promote parental education and involvement in their children's program.

b. Complete an evaluation of the effectiveness of the model and present the evaluation to the Child Development Committee of Council.

c. Meet regularly, at least once a month, with directors of all parent education projects to collaboratively disseminate a composite model program plan for parental involvement.

d. Make project plans and products available for review prior to dissemination by the Child Development Committee, the Early Intervention Task Force and the Department of Mental Retardation and Developmental Disabilities, DD Program Unit.

e. Provide consultation and technical assistance to the grantee responsible for the State Plan Activity, "Training Parents and Professionals."

Outcome Indicators

a. Extent to which the model projects continue to increase the level of parent involvement in their child's program.

b. Number of times the project directors meet jointly.

c. Existence of a composite model and extent to which it is disseminated.

d. Quality of products developed for dissemination of the models and composite model.

e. Extent to which the individual projects disseminate their models.

f. Extent to which external funding is located.

g. Degree of agency commitment to continue the parent education and involvement activities in their agencies.

h. Whether or not project products are made available for review by the Child Development Committee, the Early Intervention Task Force and the Department of Mental Retardation and Developmental Disabilities, DD Program Unit.

Projected Plan Year Funding

(4 renewal projects)	FFY 1984 (3rd year)
Federal Funds:	$ 70,000.
Non-Federal Funds:	$ 23,333.
Total:	$ 93,333.

Priority Service Area   Child Development:

Model service programs in the area.

TITLE (84-11) *Obtaining Non-Permissive Mandate for Early Identification and Intervention*

GOAL

2 To ameliorate the effects of developmental disabilities by ensuring that all children in Ohio have access to early identification and appropriate intervention services as needed.

Three Year Objective

2.2 By September 30, 1986, legislation for a strong, non-permissive mandate, with the commensurate level of appropriation, for the expansion of ongoing identification, location and evaluation of all children suspected of being handicapped, and the provision of comprehensive services for all developmentally delayed children ages 0 through 4 in the State, will have been drafted.

Plan Year Objective

2.2.1 By September 30, 1984, parent groups, state and federal legislators and other appropriate public officials will have been made aware of:

- the current status of legislation regarding early childhood education
- the importance of early intervention for handicapped children
- the cost effectiveness of early intervention for handicapped children
- the obvious gap between mandated identification, location and evaluation of all handicapped children below the age of 21 and the permissive provision of educational services for handicapped children below age 5 years
- the gap between the current fragmentation of the service delivery system and a model system of comprehensive, coordinated early intervention services to be developed under the State Plan Activity, "Establishing a Model System of Comprehensive, Coordinated Early Intervention Services."

Strategy

Funds will be made available for full time staffing of the Early Intervention Task Force by a professional familiar with the field of early intervention who will:

(1) locate, examine and synthesize data on the efficacy and cost effectiveness of early intervention services and programs to provide to the MR/DD Legislative Coalition, the Ohio Coalition for the Education of Handicapped Children, the Ohio Association for Retarded Citizens and other appropriate consumer coalitions, and (2) work closely with the coalitions named above which can (a) initiate telephone and letter writing campaigns by parents and parent groups to make state and federal legislators aware of points 1-4 above, and (b) directly inform legislators about the value and cost effectiveness of early intervention.

The full time staff person will:

(a) provide support for the Early Intervention Task Force to continue meeting on a regular basis, (b) prepare materials necessary for obtaining this objective and coordinate Task Force efforts with the various coalitions, and (c) coordinate and assist in implementation of several additional state plan objectives in the issue area of early intervention.

Responsible Agent(s)

Developmental Disabilities Planning Council
Child Development Committee
Early Intervention Task Force
Staff to Early Intervention Task Force
Advocacy Coalitions

Target Population(s)

Parents of children who are developmentally delayed
State legislators and other public officials

Anticipated Activities

a. The staff person will obtain information pertaining to: (1) the importance, value and cost effectiveness of early intervention, (2) model systems of early intervention services, (3) types of legislation being considered and/or already in effect in other states and (4) effective strategies for securing passage of legislation. Sources of such information include: the Magrab projects, the Task Force consultants and the coordination of three early identification, referral and follow-up projects located at Southwest Community Health Center, Tri-County Community Action Organization and the Cincinnati Center for Developmental Disorders, as well as reports from other states.

b. The staff person will synthesize the resource materials and prepare concise, useful information on the importance, value and cost effectiveness of early intervention for handicapped children.

c. The staff person will collaborate with staff of the MR/DD Legislative Coalition, the Ohio Coalition for the Education of Handicapped Children, Ohio Association for Retarded Citizens and other coalitions involved to ensure that the quality and format of the materials prepared by the Task Force will facilitate their appeal and usefulness for consumers and legislators.

Outcome Indicators

a. Extent to which the various coalitions support this objective and assist in the letter writing, telephone and direct information sharing activities.

b. Number of reports and resource documents prepared by the staff person for the Coalitions.

c. Extent to which the Coalitions and their staff find that the reports and data provided to them is useful in communicating the value and cost effectiveness of early intervention to state legislators.

d. Number of parents and parent groups which respond to the Coalitions' efforts to initiate a telephone and letter writing campaign.

e. Existence of a strong, non-permissive mandate with commensurate appropriation by September 30, 1986.

Projected Plan Year Funding

	FFY 1984 (1st year)	FFY 1985 (2nd year)	FFY 1986 (3rd year)
Federal Funds:	$ 32,000.	$ 33,600.	$ 35,280.
Non-Federal Funds:	$ 10,667.	$ 11,200.	$ 11,760.
Total:	$ 42,667.	$ 44,800.	$ 47,040.

Priority Service Area Child Development:

Activities to increase the capacity of institutions and agencies to provide services in the area.

TITLE (84-12) *Increasing Public and Professional Awareness of Value of Early Intervention*

GOAL

2 To ameliorate the effects of developmental disabilities by ensuring that all children in Ohio have access to early identification and appropriate intervention services as needed.

Three Year Objective

2.2 By September 30, 1986, legislation for a strong, non-permissive mandate, with the commensurate level of appropriation, for the expansion of ongoing identification, location and evaluation of all children suspected of being handicapped, and the provision of comprehensive services for all developmentally delayed children ages 0 through 4 in the State, will have been drafted.

Plan Year Objective

2.2.2 By September 30, 1984, resource materials will have been located and/or developed to increase public and professional awareness of the value and cost-effectiveness of early intervention services, and plans will have been finalized for field testing and disseminating the products.

Strategy

1. Funds will be made available for one project for a period of two years through the competitive bidding process for the search and/or development of a brochure and the production of a slide-tape and videotape presentation on the continuum of normal child development and the value and cost-effectiveness of early intervention services for children who are developmentally delayed or at risk of becoming developmentally delayed.

2. The Early Intervention Task Force and its staff will develop a plan for wide-spread dissemination of the brochure and the audio-visual products at the beginning of the second plan year. The dissemination plan will include methods to make the materials available (directly or through rotation) to the following facilities and organizations at a minimum: hospitals, health departments, planned parenthood centers, district welfare departments, parent and consumer organizations, UAPs, UAFs, County Boards of Mental Retardation/Developmental Disabilities, Head Start Programs, libraries, SERRCs, and appropriate state agencies

(Ohio Department of Mental Retardation and Developmental Disabilities, Ohio Department of Health, Ohio Department of Public Welfare). Availability of the products through libraries, SERRCs, the state agencies and the DD Council will be announced to additional groups, such as PTAs, day care centers, Lamaze and other parent preparation programs, etc.

Responsible Agent(s)

Developmental Disabilities Planning Council
Early Intervention Task Force
Early Intervention Task Force Staff
Grantee - an organization with expertise and experience in: (1) producing audiovisual materials, (2) the area of Child Development, and (3) communicating with hospitals and the medical community in order to promote the actual use of the products

Target Population(s)

General public, particularly expectant and new mothers

Anticipated Activities

a. The grantee will conduct a thorough search for current audiovisual resources describing normal child development and the value and cost effectiveness of early intervention for children who are developmentally delayed or at risk of becoming developmentally delayed.

b. The Early Intervention Task Force of the DD Council will serve as the advisory board to the organization developing the audiovisual products. The Public Awareness Campaign Coordinator will be a member of the advisory board. The advisory board will be responsible for and main-maintain authority, together with the Child Development Committee over the acceptance of the final products.

c. Major hospital associations need to be involved in an advisory capacity in the development of the videotape.

d. The Early Intervention Task Force staff person will coordinate the development of the products by the grantee and the Task Force's dissemination planning process.

e. The products will be field tested for quality, appeal and impact prior to full dissemination.

Outcome Indicators

Grantee Responsibilities:

a. Extent to which the Task Force and Child Development Committee accept the resource material developed by the grantee.

b. The response from the field-testing of the materials.

Task Force Responsibilities:

a. The number and variety of potential recipients of the brochure and viewers of the slide-tape videotape presentations identified in the dissemination plan.

b. The number of agencies that cooperate in the projected dissemination efforts by agreeing to set up a lending library or other mechanism for use of the videotapes and slide-tape presentations.

Projected Plan Year Funding

	FFY 1984 (1st year)	FFY 1985 (2nd year)
Federal Funds:	$ 25,000.	$ 5,000.
Non-Federal Funds:	$ 8,333.	$ 1,666.
Total:	$ 33,333.	$ 6,666.

Priority Service Area

Child Development:

Activities to increase the capacity of institutions and agencies to provide services in the area.

TITLE (84-13) *Establishing a Model System of Comprehensive, Coordinated Early Intervention Services*

GOAL

2 To ameliorate the effects of developmental disabilities by ensuring that all children in Ohio have access to early identification and appropriate intervention services as needed.

Three Year Objective

2.3 By September 30, 1986, a comprehensive, coordinated system of early intervention services, including a centralized referral mechanism, will have been designed for young children with or at risk of developmental delays/disabilities or other handicapping conditions.

Plan Year Objective

2.3.1 By September 30, 1984, a comprehensive, coordinated system of early intervention services feasible for implementation in Ohio will have been designed. During the second and third plan years, revisions of Federal and State laws, regulations and rules will have been made wherever possible through coordination of efforts with the MR/DD Legislative Coalition and piloting of specific components at local or state level will occur. By the end of the third plan year, the model system will be ready for implementation.

Strategy

Funds will be made available for one year to hire a consultant to assist the Early Intervention Task Force as needed in order to design a model system of comprehensive, coordinated early intervention services.

Responsible Agent(s)

Developmental Disabilities Planning Council
Early Intervention Task Force
Early Intervention Task Force Staff
Consultant
Child Development Committee

Target Population(s)

Young children with or at risk of developmental delays/disabilities or other handicapping conditions.

Anticipated Activities

a. The Task Force will continue to work with the Magrab projects and analyze information from them regarding activities necessary to be undertaken at local and state levels to develop a comprehensive early intervention system, including centralized referral mechanism, which will: (1) eliminate the duplication, (2) provide a single intake process into the system for determination of eligibility for services, and (3) ensure that parents receive information and referral covering all services for which they are eligible.

b. The consultant will: (1) analyze Ohio's present system of early intervention services, (2) review the recommendations and findings of the three local interagency collaboration efforts (Magrab projects), (3) review systems in other states and analyze applicability to Ohio, and (4) recommend alternative model systems for consideration by the Task Force.

c. The Early Intervention Task Force will continue to meet on a regular basis and use various information sources, including information available from the three Magrab projects, the DD Council activity, "Exploring and Expanding Early Intervention Services," and the consultant, to design an early intervention system for review and comment by the Child Development Committee and the DD Planning Council.

d. The Task Force will ensure that specific components of the model system will be piloted during the second and third plan years. First consideration for piloting will be given to the Magrab project sites. Level of funding for piloting will be dependent on the outcome of first year activities.

Outcome Indicators

a. The quality and relevance of the consultant's work.

b. Extent to which the three local Magrab projects are aware of expectations and, thus, provide useful material to the Task Force.

c. Extent to which a system is designed which meets criteria established by the Task Force.

Projected Plan Year Funding

	FFY 1984 (1st year)	FFY 1985 (2nd year)	FFY 1986 (3rd year)
Federal Funds:	$ 20,000.	$ 30,000.	$ 30,000.
Non-Federal Funds:	$ 6,666.	$ 10,000.	$ 10,000.
Total:	$ 26,666.	$ 40,000.	$ 40,000.

Priority Service Area   Child Development:

Activities to increase the capacity of institutions and agencies to provide services in the area.

TITLE (84-13a) *Establishing a Model System of Comprehensive, Coordinated Early Intervention Services**

GOAL

2 To ameliorate the effects of developmental disabilities by ensuring that all children in Ohio have access to early identification and appropriate intervention services as needed.

Three Year Objective

2.3 By September 30, 1986, a comprehensive, coordinated system of early intervention services, including a centralized referral mechanism, will have been designed for young children with or at risk of developmental delays/disabilities or other handicapping conditions.

Plan Year Objective

2.3.1 By September 30, 1984, a comprehensive, coordinated system of early intervention services feasible for implementation in Ohio will have been designed. During the second and third plan years, revisions of Federal and State laws, regulations and rules will have been made wherever possible through coordination of efforts with the MR/DD Legislative Coalition and piloting of specific components at local or state levels will occur. By the end of the third plan year, the model system will be ready for implementation.

Strategy

Funds will be made available for one year allocations to lead agencies of local interagency collaboration committees (Magrab projects) for administrative support services.

Responsible Agent(s)

University Affiliated Cincinnati Center for
Developmental Disorders (UACCDD)
Franklin County Board of Mental Retardation and
Developmental Disabilities (FCBMRDD)
Southeastern Ohio Voluntary Education Cooperative (SOVEC)

Anticipated Activities

The Magrab projects will, given staff and clerical support, continue to meet on an ongoing basis and will provide information pertaining to local needs/concerns which will contribute to the development of a system of early intervention services for Ohio.

Outcome Indicators

Extent to which Magrab projects continue to meet and to provide information and suggestions to the Early Intervention Task Force and to the consultant.

Projected Plan Year Funding

	FFY 1984 (1st Year)	FFY 1985 (2nd Year)	FFY 1986 (3rd Year)
Federal Funds:	$ 12,000.	To be determined	
Non-Federal Funds:	$ 4,000.		
Total:	$ 16,000.		

Priority Service Area

Child Development:

Activities to increase the capacity of institutions and agencies to provide services in the area.

*Added to Plan 2/84

TITLE (84-14) *Enhancing the Development of Early Identification and Intervention Statewide*

GOAL

2 To ameliorate the effects of developmental disabilities by ensuring that all children in Ohio have access to early identification and appropriate intervention services as needed.

Three Year Objective

2.4 By September 30, 1986, the expertise, data and experiences from three projects funded by the DD Council to develop and implement model systems of early identification, referral and follow-up for developmentally disabled or "at risk" newborns and young children will have been used to increase the potential for successful accomplishment of the following State Plan Activities:

- Drafting legislation for early identification, evaluation and intervention
- Increasing public and professional awareness of value of early intervention
- Establishing a model system of comprehensive, coordinated early identification and intervention services
- Developing a system of ongoing program evaluation
- Training parents and professionals

Plan Year Objective

2.4.1 By September 30, 1984, the awareness of leaders in the field of developmental disabilities in Ohio about issues involved in the early identification of children with developmental disabilities or at risk of having developmental disabilities will have been increased and the Early Intervention Task Force will have received information from local areas about state level changes needed to positively impact early identification and intervention efforts.

Strategy

Funds will be made available for a period of three years for allocations to Southwest Community Health Center, Cincinnati Center for Developmental Disorders and Tri-County Community Action Organization (the agencies which were funded during the period 1981-83 to develop model early identification, referral and follow-up systems), dependent upon continuation of the project activities via other funding sources. These funds will purchase one-half of each coordinator's time to assist in the successful accomplishment of the State Plan Activities listed above by completing the following responsibilities, in cooperation with and coordinated by a half-time staff person, to be hired on a personal services contract:

a. Researching the topic of early identification, exploring existing and ideal services/issues/barriers/gaps affecting early identification in Ohio and writing a concept paper for presentation to the DD Council and appropriate state and local agencies.

b. Planning and coordinating a panel presentation on early identification to the DD Council, its committees and task forces and invited guests.

c. Assisting the local leaders of the early intervention interagency collaboration committees (Magrab Projects) to ensure successful processes and outcomes and to ensure collection of data and generation of ideas to feed into the design of a model, comprehensive, statewide system of early intervention services and the draft of legislation for a strong, non-permissive mandate for the expansion of ongoing identification, location and evaluation of all children suspected of being handicapped, and the provision of comprehensive services for all developmentally delayed children or children at risk, ages 0 through 4 in the State.

d. Analyzing and using data from their own early identification referral and follow-up projects for the purposes listed immediately above.

e. Assist the Early Intervention Task Force and staff in a public awareness effort concerning the value and cost-effectiveness of early intervention.

f. Using their early identification, referral and follow-up projects as test sites for the models of ongoing program evaluation systems.

g. Facilitating interaction between each projects' parent group and the agent responsible for the State Plan Activity, "Training Parents and Professionals," and providing technical assistance to that project as appropriate.

h. Report to the Child Development Committee their model programs as examples of early identification, referral and follow-up programs as appropriate.

Responsible Agent(s)

Early Intervention Task Force Staff
Southwest Community Health Center, Inc.
The University Affiliated Cincinnati Center for Developmental Disorders
Tri-County Community Action Organization
Early Intervention Task Force
Child Development Committee

Target Population(s)

Children who are at risk for or identified as having developmental disabilities and their families.

Anticipated Activities

See Strategy above.

Outcome Indicators

a. Level and content of responses to the concept paper and panel presentation.

b. Extent to which Early Intervention Task Force finds data from funded projects useful to the designing of a comprehensive, coordinated system of Early Intervention Services.

c. Level and quality of support given to the Interagency Collaborative Committees: timeliness/usefulness of data generated by Committees for the Task Force.

d. Quality of input to drafting legislation.

e. Quality of feedback to Task Force from pilot projects.

f. Degree to which the grantee responsible for "Training Parents and Professionals" finds technical assistance helpful.

Projected Plan Year Funding

	FFY 1984 (1st year)	FFY 1985	FFY 1986
Federal Funds:	$ 35,320.	to be determined	
Non-Federal Funds:	$ 11,773.		
Total:	$ 47,093.		

Priority Service Area   Child Development:

Coordinating the provision of services in the State with the provision of other services.

TITLE (84-15) *Developing a System of Ongoing Program Evaluation*

GOAL

2 To ameliorate the effects of developmental disabililities by ensuring that all children in Ohio have access to early identification and appropriate intervention services as needed.

Three Year Objective

2.5 By September, 1986, data will exist in Ohio regarding the effectiveness and cost efficiency of early intervention programs for children with developmental delays/disabilities.

Plan Year Objective

2.5.1 By September, 1984, model(s) of program evaluation which will examine effectiveness and cost efficiency will have been reviewed and selected and plans completed for the adoption of selected model(s) by major systems offering early intervention programs in Ohio.

During the second plan year, model(s) of program evaluation selected by the Early Intervention Task Force will be adopted by the systems and implementation will begin. During the third plan year, evaluation will provide evidence about whether or not improvement is shown in the quantity, quality and comprehensiveness of service and consumer satisfaction within early intervention programs having implemented the model(s).

Strategy

Funds will be made available in FFY 1983 for an outside consultant to research and present program evaluation model(s) which are known to be effective, and examples of evaluation approaches taken by other states to the Early Intervention Task Force.

The Early Intervention Task Force/Child Development Committee will select model(s) appropriate to periodic outside evaluation and ongoing formative self evaluation with consumer input, and will work toward adoption of the model(s) within their respective systems.

Responsible Agent(s)

DD Planning Council
Child Development Committee
Early Intervention Task Force
Consultant

Target Population(s)

Department of Mental Retardation and Developmental Disabilities: County Board Programs

Ohio Department of Education: Incentive Grants and Unit Funded Classroom

Head Start Programs

University Affiliated Programs and University Affiliated Facilities

Ohio Department of Public Welfare: Early and Periodic Screening, Diagnosis and Treatment

Anticipated Activities

a. The Early Intervention Task Force will select the consultant.

b. The Early Intervention Task Force will work with the consultant, who will research model(s), review other states' activities, present information on model(s) to be integrated into existing systems, and provide the Task Force with relevant products including assessment tools.

c. Task Force members will formulate plans for introducing selected model(s) within their systems.

d. Review and comment on selected model(s) and plans for adoption/implementation will be solicited from the Child Development and Interagency Committees of Council.

Outcome Indicators

Three Year Objective:

a. Extent to which data generated demonstrates effectiveness and cost efficiency of early intervention programs in Ohio.

b. Degree of progress of children enrolled in early intervention programs using the program evaluation model(s).

Plan Year Objective:

Quality and usefulness of information provided by consultant; initial response of systems to the recommendation for adoption of model(s).

Projected Plan Year Funding

	FFY 1984 (one year)
DD Program Funds:	$ 30,000.
Non-Federal Funds:	$ 10,000.
Total:	$ 40,000.

Priority Service Area   Child Development:

Activities to increase the capacity of institutions and agencies to provide quality services in the State.

TITLE (84-16) *Training Parents and Professionals to Access Services*

GOAL

2 To ameliorate the effects of developmental disabilities by ensuring that all children in Ohio have access to early identification and appropriate intervention services as needed.

Three Year Objective

2.6 By September 30, 1986, training will have been made available to parents of children ages 0-4 with developmental delays to enable them to expand their capabilities to successfully access and maintain appropriate comprehensive services for their children and to appropriate professionals so they will understand and support the concept of parents being able to successfully access and maintain appropriate comprehensive services for their children.

Plan Year Objective

2.6.1 By September 30, 1984, a training program which will be accessible to parents of children ages 0-4, and which teaches th[illegible] successfully access and maintain appropriate comprehensive services for their children and also teaches professionals who are directly involved in IEP and IHP development to support this concept and sensitizes them to parent needs, will have been planned and begun by a currently existing parent group, which will interface with parent groups throughout the state in order to make the training responsible to local needs/capabilities in each area.

During the second plan year, in addition to providing training a conference will be planned to present to policy makers information regarding the concept, goals, curricula and methodologies, and outcomes of the training in order to attempt to have the training become incorporated into ongoing agency training programs. During the third plan year, training will continue and the conference will be held.

Strategy

Funds will be made available through the competitive bidding process for a period of three years to a parent group for a project to demonstrate training as described in the objectives above.

Responsible Agent(s)

A parent group which is accepted as grantee

Target Population(s)

Parents of developmentally delayed children ages 0-4, and professionals who are directly involved in IEP and IHP development.

Anticipated Activities

a. The grantee will review existing training materials and methodologies and use or modify them as appropriate.

b. Establish an advisory board which includes parents and professionals.

c. Contact parent groups throughout the state and plan appropriate strategies for provision of training according to local needs and capabilities, for example, offering expertise or materials to local groups already involved in such training efforts or providing training already.

d. Establish linkages with the sixteen Special Education Regional Resource Centers (SERRCs), which provide training workshops and programs for parents, in order to prevent duplication and coordinate efforts.

e. Contact DD Council grantees under the FFY 1984 activity, "Demonstrating Model Parent Education Programs," for consultation and advice regarding similar project components relevant to this objective.

f. Ensure that project trainers possess skills in adult education techniques and methodologies. Consult with the Manpower Training Task Force of the DD Council, as needed for assistance in this area.

g. Ensure that the training has been made accessible to parents of developmentally disabled children in all areas of the state by the end of the three year period.

h. Develop the training content and format in a manner which recognizes the different cultural values and the individuality of parents; i.e., their varying degrees of need for, interest in and capability for, involvement with the system and the needs of their particular child, thus providing a continuum of skill levels.

i. Periodic communication will take place between the grantee and the Early Intervention Task Force and the Child Development Committee.

j. Progress reports will be made periodically to the Child Development Committee by staff.

k. Design the training approach in a manner which encourages parent groups to adopt the concept and curriculum, so that the training becomes self-sustaining through parent volunteers.

l. Explain how this training will be continued after the grant period ends. Include actual plans, timelines and staff assignments for accomplishment of this task; i.e., ensuring continuation of the activity.

Outcome Indicators

a. Evaluation, including formal methods and anecdotal accounts, from parents and professionals.

b. Level of positive change in the system observed by non-participatory parents and professionals.

c. Extent to which local parent groups continue the effort.

d. Number of people attending and their evaluation of the conference.

Projected Plan Year Funding

	FFY 1984 (1st year)	FFY 1985 (2nd year)	FFY 1986 (3rd year)
Federal Funds:	$ 80,000.	$ 80,000.	$ 80,000.
Non-Federal Funds:	$ 26,666.	$ 26,666.	$ 26,666.
Total:	$106,666.	$106,666.	$106,666.

Priority Service Area   Child Development:

Activities to increase the capacity of institutions and agencies to provide services in the area.

TITLE (82-3) *Designing and Providing Adaptive Equipment*

GOAL

3 To enable persons with developmental disabilities to live in the least restrictive environment, existing state and federal resources will be strengthened and the development of new resources will be stimulated.

Three Year Objective

3.1 By September 30, 1986, the Regional Center for Adaptive Equipment, Montgomery County, will be self sustaining and a replication of this Center will have been initiated in another area of Ohio.

Plan Year Objective

3.1.1 The Regional Center for Adaptive Equipment, Montgomery County, will continue to exist for the design, fabrication and provision of adaptive equipment not commercially available.

Strategy

Based on monitoring and evaluation results which document successful accomplishment of existing grantee goals and objectives and their contribution toward the successful accomplishment of the FFY 1983 State Plan Housing Objective, DD Program funds will be made available through a third year grant to the FFY 1983 grantee.

Responsible Agent(s)

Montgomery County Board of Mental Retardation/Developmental Disabilities

Target Population(s)

Persons with multi-handicaps, including those individuals with developmental disabilities not currently served by the MR/DD system.

Anticipated Activities

a. Continue the advisory and consulting board which was expanded to include representatives of state agencies which (1) have the potential to provide third party reimbursement and (2) have the responsibility for habilitation planning.

b. Provide adaptive equipment for 50-75 persons with multi-handicaps.

c. Complete all policies and procedures for inclusion in a manual describing all facets of developing and implementing a multi-county adaptive equipment center.

d. Document relationships with commercial companies and other existing resources and their involvement and participation in Center activities.

e. Establish and describe all methods for becoming self sustaining.

f. Document and describe unresolved barriers to potential permanent funding sources.

g. To the extent possible, provide recommendations on a "system" for providing adaptive equipment across the state; e.g., replication of existing model, specialized models, number of centers, scope, geographic area.

Outcome Indicators

a. Degree to which the Regional Adaptive Equipment Center has become self sustaining.

b. Number of persons with multi handicaps provided with adaptive equipment.

c. Clarity and thoroughness of policies and procedure manual.

Projected Plan Year Funding

	FFY 1984 (1st year)	FFY 1983 (2nd year)	FFY 1984 (3rd year)
DD Program Funds:	$100,000.	$ 100,000.	$100,000.
Non-Federal Funds:	$ 33,333.	$ 33,333.	$ 33,333.
Total:	$133,333.	$ 133,333.	$133,333.

Priority Service Area Alternative Community Living Arrangements:

Model service programs in the area.

TITLE (84-17) *Designing Semi-Independent/Independent Living Programs with a Residential Focus*

GOAL

3 To enable all people with developmental disabilities to live in the least restrictive environment, existing state and federal resources will be strengthened and the development of new resources will be stimulated.

Three Year Objective

3.2 By September 30, 1986, comprehensive fiscal and programmatic plans will exist which describe all federal, state and local components necessary for the development of semi-independent/independent living programs in Ohio. Implementation of these plans will result in the existence of permanent semi-independent/independent living programs in selected areas.

Plan Year Objective

3.2.1 Comprehensive fiscal and programmatic plans which describe all federal, state and local components necessary for the development of semi-independent/independent living programs will have been designed to ensure their implementation in one rural and one urban area.

Strategy

DD Program funds will be made available for one year through the competitive grant process. Second and third year funds may be available to assist in implementation of the plans based on the degree to which the plan targets the permanent existence of semi-independent/independent living programs in Ohio and describes how, with changes in the system, it can be implemented within the target area.

Responsible Agent(s)

One rural and one urban public or non-profit organization with a commitment and ability to design and provide services with respect to persons with Spina Bifida, persons with Cerebral Palsy, persons with Autism, persons with Mental Retardation, etc.

Target Population(s)

All persons with developmental disabilities to include those individuals with developmental disabilities not currently served by the MR/DD system.

Anticipated Activities

Note: The following activities are recommended by the Ohio Developmental Disabilities Planning Council. Alternative activities which would accomplish the plan year objective and contribute in a systematic fashion to the attainment of the three year objective would be considered.

a. Secure a copy of the Residential Services Position Paper.

b. Adhere to guidelines on a home-centered approach to residential services as presented in Position Paper.

c. Design a comprehensive fiscal and programmatic plan for the development of semi-independent/independent living programs for persons with developmental disabilities which address the following:

- research of existing program models
- description and definition of geographic target area for potential implementation of plan
- description of public and personal financial resources
- description of community support resources, both formal and informal
- detailed description of a variety of living options to be included in the program
- description of overall needs of individuals who may reside in these living options
- how resources identified can be used to meet identified need
- analysis of all barriers to program implementation, to certain of the living options, to use of community, personal and public resources
- clearly articulated strategies which are designed to overcome the barriers
- description of the activities, methods, agreements, etc., for informing and involving key actors and for establishing service linkages between all agencies and organizations in the community and the semi-independent/independent living programs
- detailed description of how the plan would be implemented within the target area as a result of implementing strategies which would overcome identified barriers

Outcome Indicators

a. Degree to which plan design reflects the guidelines of the Residential Services Position Paper.

b. Extent to which the plan documents a comprehensive fiscal and programmatic design for the permanent development of semi-independent/independent living programs.

Projected Plan Year Funding

	FFY 1984 (1st year)	FFY 1985 (2nd year)	FFY 1986 (3rd year)
DD Program Funds:	$ 54,730.	to be determined	to be determined
Non-Federal Funds:	$ 18,243.		
Total:	$ 72,973.		

Priority Service Area Alternative Community Living Arrangements:

Activities to increase the capacity of institutions and agencies to provide services in the area.

TITLE (84-17a) *Designing Semi-Independent/Independent Living Programs with a Residential focus**

GOAL

3 To enable all people with developmental disabilities to live in the least restrictive environment, existing state and federal resources will be strengthened and the development of new resources will be stimulated.

Three Year Objective

3.2 By September 30, 1986, comprehensive fiscal and programmatic plans will exist which describe all federal, state and local components necessary for the development of a system of semi-independent/independent living programs in selected areas.

Plan Year Objective

3.2.2 A comprehensive plan will have been developed and approved by the Ohio Department of Mental Retardation and Developmental Disabilities (ODMR/DD) for analyzing the data gathered by the recipients of grants numbered 84-17 to determine rule, policy and procedure changes necessary to the implementation of a system of semi-independent/independent living programs for people with developmental disabilities.

Strategy

The ODMR/DD will designate an individual to establish linkage with the urban and rural grantees (84-17) which will assist ODMR/DD to plan for statewide implementation of a system of semi-independent/independent living programs.

Responsible Agent(s)

The Ohio Department of Mental Retardation and Developmental Disabilities (ODMR/DD).

Target Population

All persons with developmental disabilities to include those individuals with developmental disabilities not currently served by the MR/DD system.

Anticipated Activities

Note: The following activities are recommended by the Ohio Developmental Disabilities Planning Council. Additional alternative activities which would accomplish the plan year objective and contribute in a systematic fashion to the attainment of the three year objective would be considered.

a. Secure a copy of the Residential Services Position Paper.

b. Adhere to guidelines on a home-centered approach to residential services as presented in the Position Paper.

c. Designate ODMR/DD staff person(s) to be responsible for linkage with the urban and rural grantees.

   - develop inventory of existing semi-independent/independent living options in the State of Ohio.

   - provide information to proposed providers on semi-independent/independent living options including the philosophy of the Residential Services Position Paper and components of the urban and rural grantees models.

   - design a plan to analyze the data generated by the urban and rural grantee.

   - design a plan for implementation of rule, policy and procedure as indicated by the data generated by the rural and urban grantees.

   - serve on appropriate advisory councils of both urban and rural grantees.

   - review and comment on chapters of "Manual" to be developed by urban grantee.

   - participate with grantees in identifying systemic barriers and strategies.

   - participate in analyzing POS Rules regarding SSI funds.

   - participate in analyzing Medicaid Waiver regarding semi-independent/independent living.

   - assure that information from urban and rural grantees contribute to ODMR/DD State Plan.

   - analyze and develop an ODMR/DD position paper on state level policy regarding semi-independent/independent living in keeping with the Residential Services Position Paper with assistance from urban and rural grantees.

   - keep ACLA (Alternative Community Living Arrangements) Committee staff person apprised of activities and report to ACLA upon request.

Outcome Indicators

a. Designated ODMR/DD staff person(s) responsible for linkage with the rural and urban grantees for semi-independent/independent living project.

b. Inventory of existing semi-independent/independent living programs for persons with developmental disabilities in Ohio.

c. Technical assistance in written form disseminated to proposed providers about semi-independent/independent living programs.

d. Plan designed for analyzing information from urban and rural grantees.

e. Plan designed for implementation of rule, policy and procedure as initiated by the data gathered by the grantees.

f. Position paper developed on state level policy regarding semi-independent/independent living options.

Project Plan Year Funding: None

Priority Service Area Alternative Community Living Arrangements:

Activities to increase the capacity of institutions and agencies to provide services in the area.

*Added to Plan 12/83

TITLE (84-18) *Comprehensive Family Support*

GOAL

3 To enable all people with developmental disabilities to live in the least restrictive environment, existing state and federal resources will be strengthened and the development of new resources will be stimulated.

Three Year Objective

3.3 By September 30, 1986, a report will exist which describes a quality service/brokerage model for the provision of comprehensive family support and how the information from the model can be used to ensure the permanent existence of a family support system in Ohio.

Plan Year Objective

3.3.1 A quality service/brokerage model for the provision of comprehensive family support will have been designed and implementation of the model will have been initiated in a rural area and an urban area.

Strategy

DD Program funds will be made available for three years through the competitive grant process.

Responsible Agent(s)

One rural and one urban public or non-profit organization

Target Population(s)

Persons with developmental disabilities and their families, including those individuals and their families not currently served by the MR/DD system.

Anticipated Activities

Note: The following activities are recommended by the Ohio Developmental Disabilities Planning Council. Alternative activities which would accomplish the plan year objective and contribute in a systematic fashion to the attainment of the three year objective would be considered.

a. Secure copies of Residential Service Position Papers, Family Support Position Papers.

b. Adhere to philosophy and guidelines as articulated in Position Papers.

c. Define service area and identify the extent of family support needs including but not limited to:

   - parent/guardian training
   - special therapy
   - adaptive equipment
   - home maker service
   - home renovation
   - home health care
   - respite
   - recreation
   - medical care
   - transportation
   - counseling
   - special diets
   - legal services
   - day care
   - support groups

d. Identify and document all families eligible for family support; establish criteria for selection of families to participate in model development.

e. Identify all existing resources, both specialized and generic.

f. Establish linkages with letters of support from existing resources.

g. Research existing service models.

h. Develop and begin implementing a plan that reflects a quality service model for the provision of comprehensive family support for selected families; clarify any associated issues.

i. Document and clarify barriers to provision of any service component.

j. Design and document strategies to resolve barriers.

k. Establish ongoing advisory board to ensure meaningful consumer involvement.

l. Provide public relations information on family support concept to families and community.

m. Document preliminary strategies for using model information to ensure state level implementation.

Outcome Indicators

a. Degree to which policies and procedures reflect the philosophy of the Residential Services and Family Support Position Papers.

b. Degree to which all components of a comprehensive family support model have been analyzed and documented.

c. Extent to which a comprehensive family support plan has been implemented.

Projected Plan Year Funding

	FFY 1984 (1st year)	FFY 1985 (2nd year)	FFY 1986 (3rd year)
DD Program Funds:	$ 37,760.	To be determined	To be determined
Non-Federal Funds:	$ 12,587.		
Total:	$ 50,347.		

Priority Service Area Alternative Community Living Arrangements:

Activities to increase the capacity of institutions and agencies to provide services in the area.

TITLE (84-18a) *Comprehensive Family Support/Accessing Specialized and Generic Services**

GOAL

To enable all people with developmental disabilities to live in the least restrictive environment, existing state and federal laws will be strengthened and the development of new resources will be stimulated.

Three Year Objective

3.3a By September 30, 1986, a permanent statewide system will exist for the provision of comprehensive family support and case coordination to include accessing specialized and generic services.

Plan Year Objective

3.3a.1 A preliminary statewide system will have been designed and state level strategies developed by the Ohio Department of Mental Retardation and Developmental Disabilities (ODMR/DD) to ensure the provision of comprehensive family support including accessing generic and specialized services.

Strategy

Developmental Disabilities Program Funds will be allocated to the ODMR/DD for the hiring of an individual to design and initiate implementation of a preliminary system and state level strategies necessary to the provision of comprehensive family support.

Responsible Agent(s)

The Ohio Department of Mental Retardation and Developmental Disabilities (ODMR/DD)

Target Population(s)

Persons with developmental disabilities and their families including those not currently served by the MR/DD system.

Anticipated Activities

Note: The following activities are recommended by the Ohio Developmental Disabilities Planning Council. Additional alternative activities which would accomplish the plan year objective and contribute in a systematic fashion to the attainment of the three year objective would be considered.

a. Establish a linkage with the recipient of Grant #84-18 via the ODMR/DD DD hiring of a staff individual with expertise in the area of Ohio's various service delivery systems. Activities of the ODMR/DD staff to include but not be limited to the following:

- secure copies of the DD Council's Residential Services Position Paper and the DD Council's Family Support Position Paper

- adhere to philosophy as articulated in Position Papers

- analyze and develop a Position Paper on State level policy regarding comprehensive family support and accessing specialized and generic services

- complete study by April 1, 1985, of existing program options and alternative financial resources for community based services, including specialized and generic services, throughout the State to include detailed analysis of costs for various service combinations in various residential settings and geographical areas. Service areas will include, but not be limited to, the following:

    - parent/guardian training
    - special therapy
    - adaptive equipment
    - home maker service
    - home renovation
    - home health care
    - respite
    - recreation
    - medical care
    - transportation
    - counseling
    - special diets
    - legal services
    - day care
    - support groups

- document and clarify barriers to provision of any service component

- design and document strategies to resolve barriers

- assist when appropriate, grantee 84-18 staff in accessing potential providers locally

- use information gained from project to train appropriate staff in geographical areas other than grantees regarding various service options and how to achieve access

- provide direct assistance to appropriate ODMR/DD staff to achieve access to specialized and generic services to MR/DD clients
- assure than information from project will contribute to ODMR/DD State Plan
- develop State level strategies including initiation of a design for implementation of comprehensive family support in Ohio
- keep Alternative Community Living Arrangements Committee staff person apprised of activities and report to ACLA Committee upon request

Outcome Indicators

a. State level strategies will have been developed that promote the provision of comprehensive family support on a statewide basis to include accessing specialized and generic services.

b. Existence of a preliminary design for a statewide system of effective case coordination services that will support and facilitate the provision of comprehensive family support services on a statewide basis.

c. A Position Paper will exist on State level policy regarding comprehensive family support and accessing specialized and generic services.

d. Extent and degree to which ODMR/DD linkage with grantee #84-18 exists.

e. Extent and degree to which ODMR/DD staff have been trained in various service options and how to access them.

Projected Plan Year Funding	FFY 1984
DD Program Funds:	$ 24,034.
Non-Federal Funds:	$ 8,011.
Total:	$ 32,045.

Priority Service Area Alternative Community Living Arrangements:

Activities to increase the capacity of institutions and agencies to provide services in the area.

*Added to Plan 12/83

TITLE (84-19) *Family Resources Program*

GOAL

3 To enable people with developmental disabilities to live in the least restrictive environment, existing state and federal resources will be strengthened and the development of new resources will be stimulated.

Three Year Objective

3.4 By September 30, 1986, a permanent source of funding will exist for the provision of respite and other family resources and administrative and programmatic guidelines and program development will reflect the philosophy of respite, and other family resources service provision as supported by the Developmental Disabilities Planning Council.

Plan Year Objective

3.4.1 Council will support the Family Resources Program.

Strategy

DD Program funds will be allocated through the contract process.

Responsible Agent(s)

DD Planning Council
Contract Staff

Target Population(s)

Persons with developmental disabilities and their families, including those individuals and their families not currently served by the MR/DD system.

Anticipated Activities

The Ohio Developmental Disabilities Planning Council will contract with two part-time individuals for the provision of technical assistance and education for consumers, providers, and administrators in order to facilitate the implementation of the Family Resources Program including fostering the development of philosophically sound administrative rules and service programs.

Outcome Indicators

The degree to which new family resources programs reflect the service philosophy of the Ohio Developmental Disabilities Planning Council.

Projected Plan Year Funding

	FFY 1984 (1st year)	FFY 1985 (2nd year)	FFY 1986 (3rd year)
DD Program Funds:	$ 42,562.	To be determined	To be determined
Non-Federal Funds:	$ 14,187.		
Total:	$ 56,749.		

Priority Service Area   Alternative Community Living Arrangements:

Activities to increase the capacity of institutions and agencies to provide service in the area.

TITLE (84-20) *Printing and Dissemination of a Position Paper - "Respite Services as a Component of Comprehensive Family Support"*

GOAL

3 To enable people with developmental disabilities to live in the least restrictive environment, existing state and federal resources will be strengthened and the development of new resources will be stimulated.

Three Year Objective

3.4 By September 30, 1986, a permanent source of funding will exist for the provision of respite services and administrative and programmatic guidelines will reflect the philosophy of respite service provision as supported by the Ohio Developmental Disabilities Planning Council.

Plan Year Objective

3.4.2 By September 30, 1985, the Position Paper - "Respite Services as a Component of Comprehensive Family Support" will have been printed and disseminated to a wide variety of policy makers and existing and potential service providers.

Strategy

DD Program funds will be allocated for a graphic arts consultant, printing and dissemination costs.

Responsible Agent(s)

Alternative Community Living Arrangements Committee
DD Planning Council

Target Population(s)

Members of the Respite Coalition; County Boards of Mental Retardation and Developmental Disabilities; Ohio Legislators; mayors of Ohio cities; Metropolitan Human Services Commission; all groups applying for residential licensure; regional health planning associations; Ohio Private Residential Association; Association of Ohio Philanthropic Homes for the Aging (AOPHA); Ohio Health Care Association; key individuals in the Ohio Department of Mental Retardation/Developmental Disabilities; participants of major Ohio conferences and workshops, etc.

Outcome Indicators

a. Professional quality of printed position paper.

b. Thoroughness of dissemination plan and its implementation.

Projected Plan Year Funding

	FFY 1984 (one year)
DD Program Funds:	$ 5,000.
Non-Federal Funds:	$ 1,666.
Total:	$ 6,666.

Priority Service Area   Alternative Community Living Arrangements:

Activities to increase the capacity of institutions and agencies to provide services in the area.

TITLE (84-21) *Promoting Adoption as a Viable Alternative for Children with Developmental Disabilities*

GOAL

3 To enable people with developmental disabilities to live in the least restrictive environment, existing State and Federal Resources will be strengthened and the development of new resources will be stimulated.

Three Year Objective

3.5 By September 30, 1986, plans consistent with the principle of normalization, will have been developed and implemented which articulate the elements and processes necessary for accessing all generic and specialized services for persons with developmental disabilities needing such services and which document services not available.

Plan Year Objective

3.5.1 Issues will have been examined and strategies will have been designed which will contribute to the development of policies, procedures and resources which are committed to adoptive placement for all eligible children with developmental disabilities in Ohio.

Strategy

Council staff will work with former DD grantees in the area of adoption to formulate plans.

Responsible Agent(s)

DD Council
Council Staff

Target Population(s)

Children with developmental disabilities who are free for adoption.

Anticipated Activities

a. Council will continue to work with DD adoption projects and other key actors in order to determine the most appropriate and effective strategies for the development of policies, procedures and resources which are committed to adoptive placement for all eligible children with developmental disabilities in Ohio.

Outcome Indicators

a. The extent to which generic adoption agencies are successfully finding placements for children with developmental disabilities.

Projected Plan Year Funding

None

Priority Service Area Alternative Community Living Arrangements:

Activities to increase the capacity of institutions and agencies to provide services in the area.

TITLE (84-23) *Action Plan for Carrying Out Recommendations from the Deinstitutionalization Task Force Report**

GOAL
4

To enable persons with developmental disabilities to live in the least restrictive environment and to enhance services to persons with developmental disabilities who have been and are being released under Ohio's Department of Mental Retardation/Developmental Disabilities deinstitutionalization effort.

Three Year Objective

4.2 By September 30, 1986, major written recommendations which resulted from the efforts of the Deinstitutionalization Task Force will have been implemented in Ohio.

Plan Year Objective

4.2.1 Action Plans will have been designed that target the most critical issues related to the provision of services for persons with developmental disabilities as documented in the Deinstitutionalization Task Force Report and where appropriate and feasible, implementation of Task Force Report recommendations will have commenced.

Strategy

DD Program Funds will be made available for one year through an allocation to Nisonger Center

Responsible Agent(s)

Nisonger Center
Ohio Developmental Disabilities Planning Council

Target Population(s)

Persons with developmental disabilities who are or have been residents of Ohio's institutions and state and local policy makers, all major advocacy groups, other local planning bodies, other consumers, professionals, higher education facilities and general citizenry.

Anticipated Activities

a. Based on the final report from the Deinstitutionalization Task Force, the review, modification and/or approval of the Report by the DD Council and significant other groups, identify major issues to be addressed, e.g., adult services, purchase of service system, employee protection rights, use of genetic services, etc.

b. Design, in collaboration with key actors, action plans to address major issues.

c. Provide verbal and written status reports on all activities and action plans to the Alternative Community Living Arrangements Committee and to the DD Council as appropriate.

d. Design and provide training and orientation for key actors, consumers, professionals in the developmental disabilities field and other targeted groups in the quality of life principles and values which serve as the foundation and directing guidelines for the Deinstitutionalization Task Force.

e. Consultant(s) will be hired for design, graphics, editing, production and dissemination of all Deinstitutionalization Task Force Position Papers.

Outcome Indicators

a. Timelines, clarity, thoroughness of action plans, including training and orientation activities.

b. Professional quality of printed position papers.

c. All Deinstitutionalization Task Force Position Papers will have been printed and disseminated to a wide variety of policy makers, existing and potential providers, and appropriate professionals in the developmental disabilities field.

d. A comprehensive plan for valued based orientation and training will have been designed and developed necessary for statewide implementation.

Projected Plan Year Funding

	FFY 1984 (one year)
DD Program Funds:	$ 72,016.
Non-Federal Funds:	$ 24,006.
Total:	$ 96,022.

Priority Service Area   Alternative Community Living Arrangements:

Activities to increase the capacity of institutions and agencies to provide services in the area.

*Text amended and allocation increased 12/83

TITLE (84-24) *Development of a Training System for Persons Serving Individuals with Developmental Disabilities and Related Severe Behavior Problems*

GOAL

5 To ensure that the service needs of persons with Developmental Disabilities and Related Special Needs (such as severe behavior problems and aging), are recognized and provided for at both state and local levels.

Three Year Objective

5.1 A comprehensive and self sustaining training system will exist to meet the needs of individuals who serve persons with developmental disabilities and related severe behavior problems.

Plan Year Objective

5.1.1 An expert development and implementation team will have been established to provide for the training of a minimum of 12 staff trainers, to develop a staff training program and to conduct inservice orientations for persons serving individuals with developmental disabilities and related severe behavior problems.

Strategy

DD Program funds will be made available for three years through the competitive grant process.

Responsible Agent(s)

A public or private non-profit organization with demonstrated experience in serving persons with developmental disabilities and related severe behavior problems, staff development for individuals who work in such programs, a basic competency and understanding of adult education principles and some evaluative results that document "good" training endeavors in the past.

Target Population(s)

Individuals who serve persons who have developmental disabilities with related severe behavior problems.

Anticipated Activities

NOTE: The following activities are recommended by the Ohio Developmental Disabilities Planning Council. Alternative activities which would accomplish the plan year objective and contribute in a systematic fashion to the attainment of the three year objective would be considered.

a. Recruit a project coordinator who has demonstrated expertise in adult education principles and staff training related to developmental disabilities and severe behavior problems.

b. Provide clerical support for the project.

c. Establish a four (4) member, paid, development and implementation team. Representatives would include a cross representation of individuals who have demonstrated expertise in adult education strategies, severe behavior management and developmental disabilities. The systemic manpower training consultant to the Ohio DD Planning Council's Manpower Training Task Force would also serve at no cost to the project. The team would assist with the development and implementation of the training of staff trainers' education program.

d. Develop and implement a comprehensive, longitudinal plan for the training of staff trainers. The plan would include at a minimum:

- description of: (1) the behavior of persons with developmental disabilities and severe behavior problems (description should include a review of the assessment tool, "behavior severity levels, persons who may be in need of additional services" developed by the Ohio Department of Mental Retardation/Developmental Disabilities, Purchase of Service Task Force Subcommittee) and, (2) related staff training needs

- identification and selection of existing training packages/materials related to severe behavior problems and adult education strategies. These materials would be used for completion of the following six items:

- description of training content areas to include (1) comprehensive prevention and intervention strategies (training needs to encompass more than just traditional behavior modification techniques, e.g., a variety of behavior change approaches, instructional techniques and relevant philosophy and values), (2) adult education strategies and (3) systemic manpower training approaches, e.g., participant agency commitment should include an organizational mechanism for permanence beyond just having trained staff train other staff and the project coordinator needs to establish a consultative relationship with the administration of the participating agencies and facilitate a consultative relationship between the staff trainer in the agency and the administration of the agency

- development of competencies related to training content areas and evaluation procedures specific to those competencies

- description of adult staff training methodologies

- modification of existing relevant training materials and development of new materials where none exist

- description of prerequisite competencies of participant staff trainers and procedures for evaluation of those competencies

- compilation of two training packages; (1) to be used by and given to participant staff trainers for use in training staff who serve persons with developmental disabilities and severe behavior problems and (2) materials which will be used by staff trainers to enhance and increase the skills and knowledge of individuals who serve persons with developmental disabilities and severe behavior problems. The training packages would be reviewed by the Ohio Developmental Disabilities Planning Council Manpower Training Task Force during the outline, rough, and final draft stages.

- design for recruitment of participant staff trainers in collaboration with the Ohio DD Planning Council's Alternative Community Living Arrangements Committee and the Manpower Training Task Force. Recruitment design should ensure equal representation across the state for both urban and rural areas with a particular emphasis on the rural areas.

- negotiation and letters of commitment from public or non-profit service providers for staff to serve as participant staff trainers. Letters of commitment would include the following provisions:

  - the agency agrees to provide staff member who meets the identified prerequisite competencies to serve as a participant staff trainer.

  - during the first project year each participant staff trainer would participate in a training of staff trainer's education program and receive needed follow-up technical assistance.

  - during the second and third project years each participant staff trainer would participate in follow-up training and receive technical assistance.

  - during the second and third project years each participant staff trainer would implement severe behavior management training, training evaluation, and follow-up technical assistance for staff who serve persons with developmental disabilities and severe behavior problems both within the staff trainer's agency and outside of the staff trainer's agency. The number of persons to be trained and the rate of compensation for training which will occur outside of the staff trainer's agency will be negotiated with the project coordinator and the project team prior to initiation of training.

Training would be coordinated with existing Local Manpower Consortia as established through the Ohio DD Planning Council's Manpower Training Task Force.

  - conditions (scheduling, practicum, etc.) under which training of staff trainers would occur.
  - pending continued employment with the contract agency, during fiscal years '84-'85, '85-'86, and '86-'87, each participant staff trainer would continue activities as outlined above without subsidy from the project.

- initiate the provision of staff trainers training on an intensive, longitudinal basis for 12 participant staff trainers, representative of geographic distribution, at centrally located sites. Training would have to include supervised practicum experience, i.e., demonstration of the successful training of a minimum of one staff, and the conditions, including scheduling, under which training of staff trainers would occur as agreed upon in negotiated letters of commitment.
- provision of follow-up technical assistance for participant staff trainers as indicated.
- conduct overview presentations/orientations on severe behavior management for interested staff, parents, etc.
- internal evaluation of project.

e. Quarterly presentations concerning project activities to the Ohio DD Planning Council's Alternative Community Living Arrangements Committee via the Council's Manpower Training Task Force.

Outcome Indicators

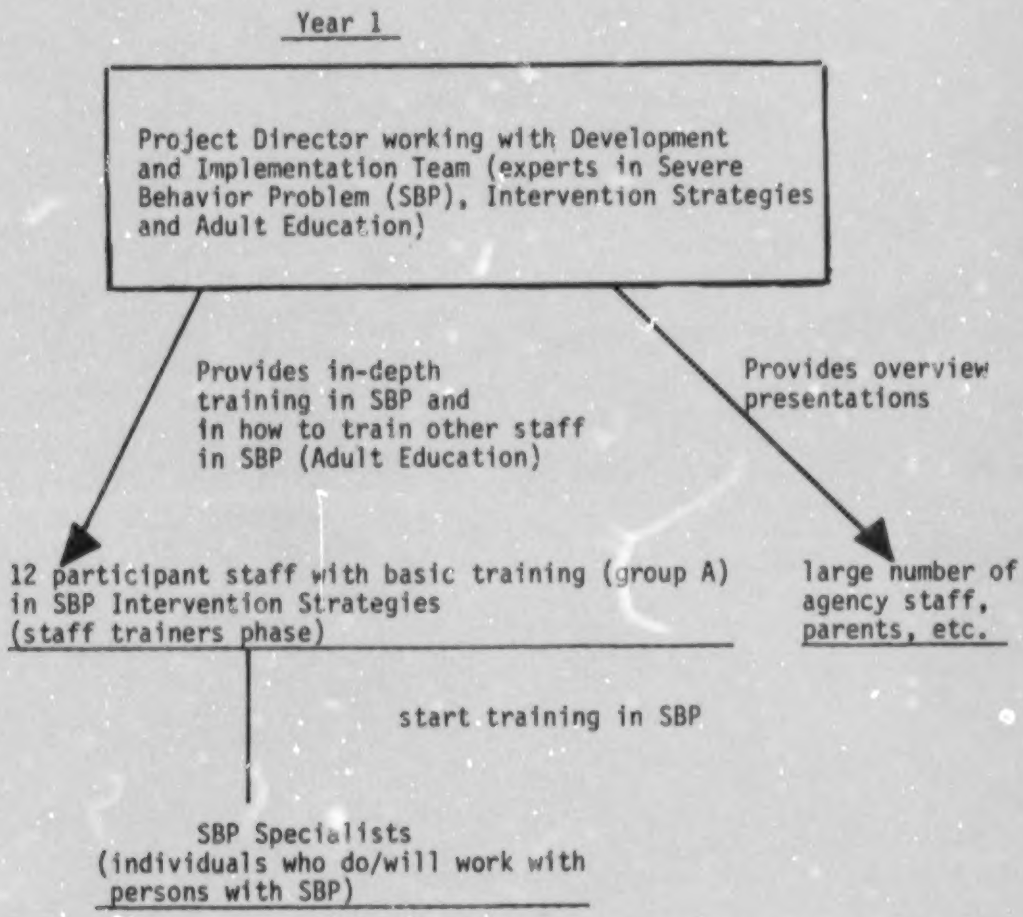
a. Degree to which participant staff trainers demonstrate specified competencies in serving persons with developmental disabilities and severe behavior problems, implementing Adult Education programs and utilizing systemic manpower training approaches.

b. Degree to which individuals who serve persons with developmental disabilities and severe behavior problems acquire skills and knowledge that enhance this service role.

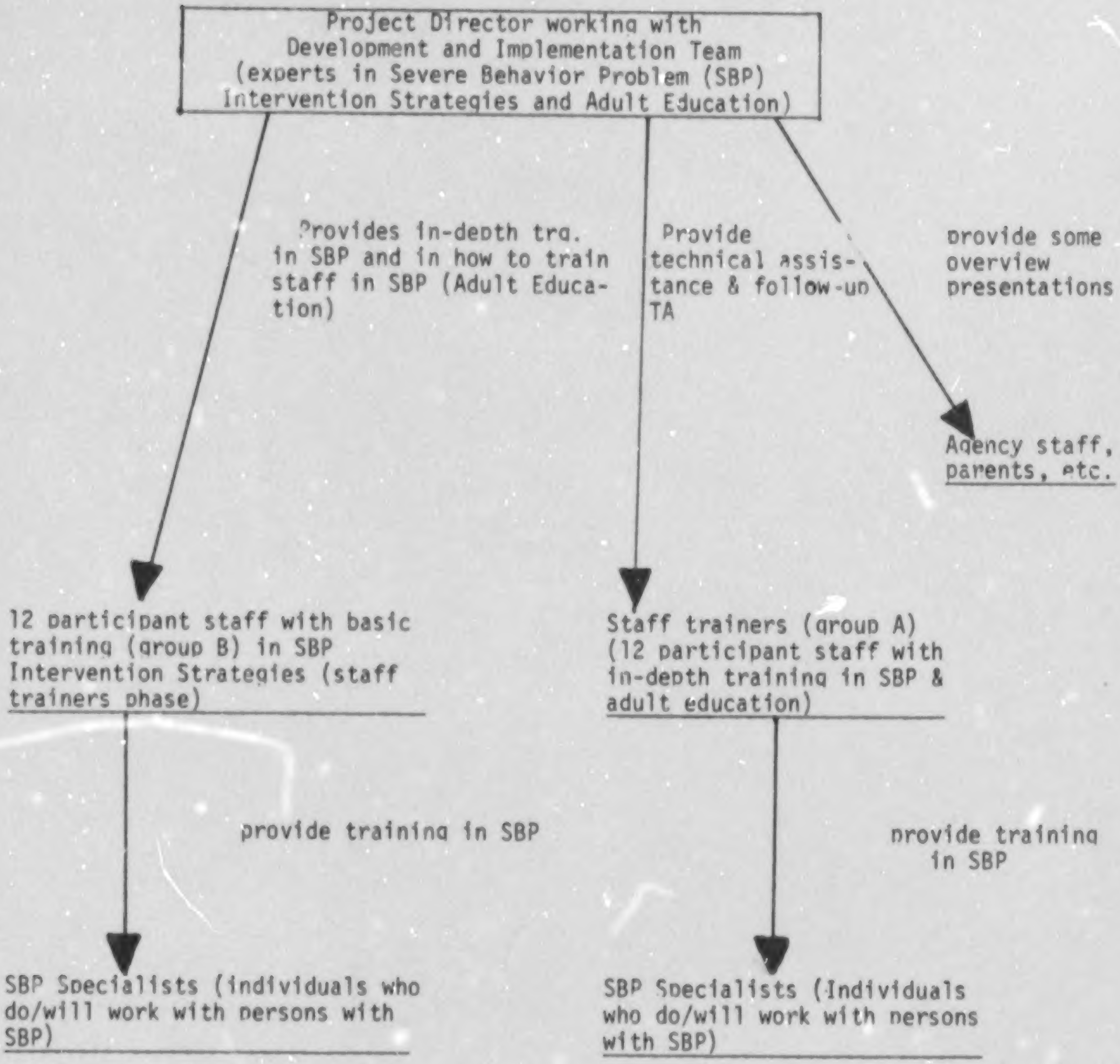
c. The extent to which identified training objectives are relevant to meeting the needs of persons with developmental disabilities and severe behavior problems.

d. Quality of prototype training packages, one for training of staff trainers and one for the training of staff who serve persons with developmental disabilities and severe behavior problems.

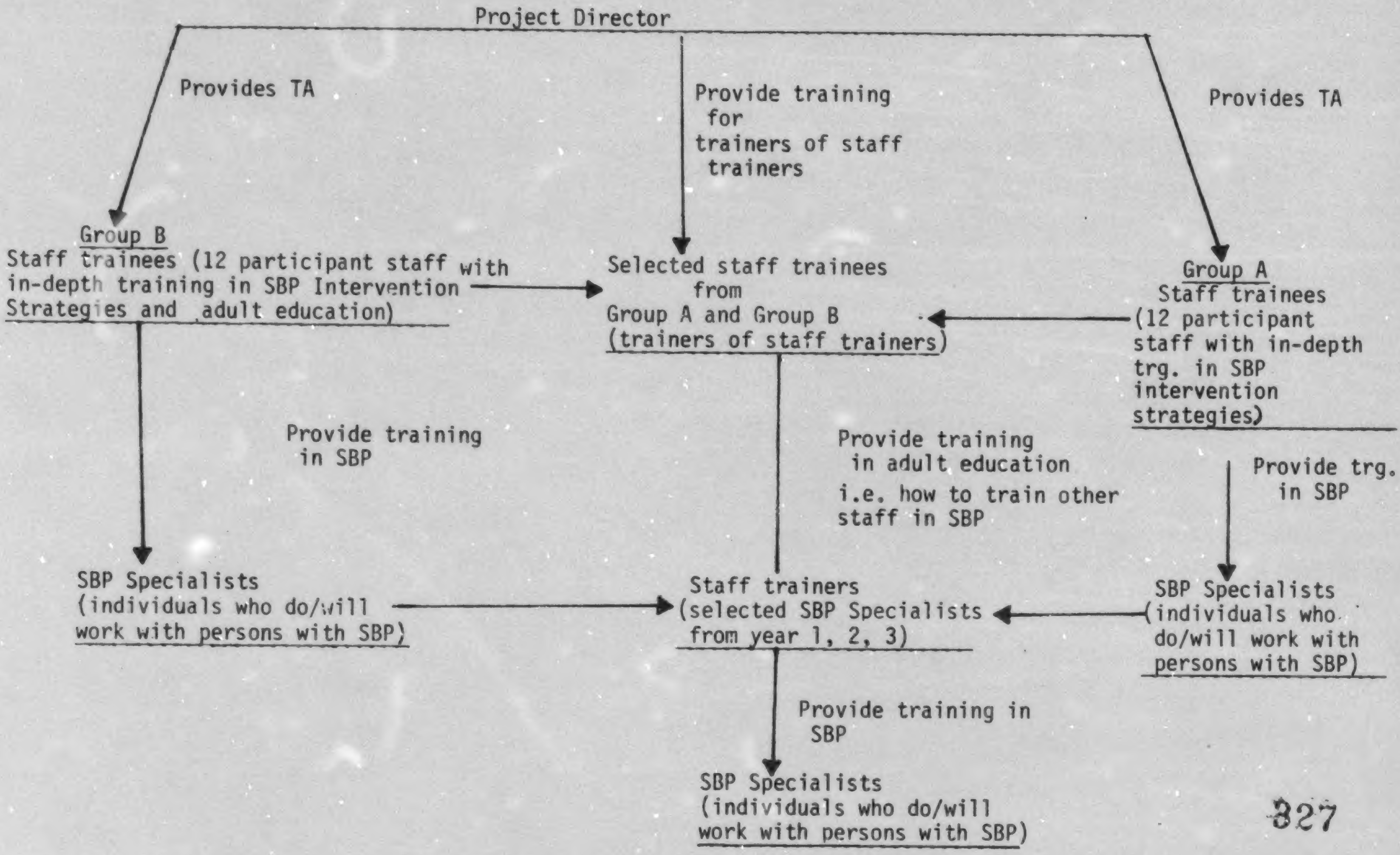
GRAPHIC DISPLAY OF THE DEVELOPMENT OF A TRAINING SYSTEM FOR PERSONS SERVING INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES AND RELATED SEVERE BEHAVIOR PROBLEMS


Year 1
Project Director working with Development and Implementation Team (experts in Severe Behavior Problem (SBP), Intervention Strategies and Adult Education)
Provides in-depth training in SBP and in how to train other staff in SBP (Adult Education)
Provides overview presentations
12 participant staff with basic training (group A) in SBP Intervention Strategies (staff trainers phase)
large number of agency staff, parents, etc.
start training in SBP
SBP Specialists (individuals who do/will work with persons with SBP)

Year 2


Project Director working with Development and Implementation Team (experts in Severe Behavior Problem (SBP) Intervention Strategies and Adult Education)
Provides in-depth trg. in SBP and in how to train staff in SBP (Adult Education)
Provide technical assistance & follow-up TA
provide some overview presentations
Agency staff, parents, etc.
12 participant staff with basic training (group B) in SBP Intervention Strategies (staff trainers phase)
Staff trainers (group A) (12 participant staff with in-depth training in SBP & adult education)
provide training in SBP
provide training in SBP
SBP Specialists (individuals who do/will work with persons with SBP)
SBP Specialists (Individuals who do/will work with persons with SBP)

Year 3


Project Director
Provides TA
Provide training for trainers of staff trainers
Provides TA
Group B
Staff trainees (12 participant staff with in-depth training in SBP Intervention Strategies and adult education)
Selected staff trainees from Group A and Group B (trainers of staff trainers)
Group A
Staff trainees (12 participant staff with in-depth trg. in SBP intervention strategies)
Provide training in SBP
Provide training in adult education i.e. how to train other staff in SBP
Provide trg. in SBP
SBP Specialists (individuals who do/will work with persons with SBP)
Staff trainers (selected SBP Specialists from year 1, 2, 3)
SBP Specialists (individuals who do/will work with persons with SBP)
Provide training in SBP
SBP Specialists (individuals who do/will work with persons with SBP)

e. Documentation of initiation of self sustaining training program via written letters of commitment for participant staff trainers.

Projected Plan Year Funding

	FFY 1984 (1st year)	FFY 1985 (2nd year)	FFY 1986 (3rd year)
DD Program Funds:	$ 117,000.-$157,000.	$ 113,000.-$153,000.	To be Determined
Non-Federal Funds:	$ 39,000.-$ 52,333.	$ 37,666.-$ 51,000.	
Total:	$ 156,000.-$209,333.	$ 150,666.-$204.000.	

Priority Service Area Alternative Community Living Arrangements:

Training of personnel to provide services in the area.

TITLE (84-25) *Dissemination and Replication of the Mental Retardation and Developmental Disabilities and Aging Committee of the Northeastern Ohio Consortium in Geriatric Medicine and Gerontology*

GOAL

5 To ensure that the service needs of persons with developmental disabilities and related special needs (such as severe behavior problems and aging), are recognized and provided for at both state and local levels.

Three Year Objective

5.2 By September 30, 1986, the Mental Retardation and Developmental Disabilities and Aging Committee of the Northeastern Ohio Consortium in Geriatric Medicine and Gerontology will be replicated in 3/4 areas of Ohio and a permanent mechanism will exist to provide for the ongoing training needs of staff from both service areas (MR/DD and Aging) who serve older adults with MR/DD.

Plan Year Objective

5.2.1 Based on information provided through the development of a research monograph, inservice training modules will have been developed and competency based training will have occurred in 5 areas of the state for staff in agencies who provide services for older adults with MR/DD.

Materials and plans will exist which provide for the replication of the Mental Retardation/Developmental Disabilities and Aging Committee and for a permanent mechanism to provide ongoing training for staff who serve older adults with MR/DD.

Strategy

DD Program Funds will be allocated to Akron University, Department of Counseling and Special Education through the Northeastern Ohio Consortium in Geriatric Medicine and Gerontology, Mental Retardation and Developmental Disabilities and Aging Committee.

Responsible Agent(s)

Ohio Developmental Disabilities Planning Council
Northeastern Ohio Consortium in Geriatric Medicine and Gerontology
Akron University, Department of Counseling and Special Education
Mental Retardation and Developmental Disabilities and Aging Committee

Target Population(s)

Persons with MR/DD who are aging and aged including those individuals not being currently served by the MR/DD system.

Anticipated Activities

NOTE: The following activities are recommended by the Ohio Developmental Disabilities Planning Council. Alternative activities which would accomplish the plan year objective and contribute in a systematic fashion to the attainment of the three year objective would be considered.

a. Recruit a project coordinator who has demonstrated expertise in MR/DD, adult education principles, staff development and training and exposure to and knowledge of the needs of older adults.

b. Provide clerical support for the project.

c. Convene the Mental Retardation/Developmental Disabilities and Aging Committee of the Northeastern Ohio Consortium in Geriatric Medicine and Gerontology on a regular basis to function in an advisory capacity to the project.

d. Participate on the multi-county interagency training consortium (if located in the area) established through the implementation of the 1984-86 DD State Plan.

e. Develop and produce a monograph which articulates the background, purpose, scope, results, recommendations and conclusions of the 1983 research project conducted under the auspices of the Mental Retardation/ Developmental Disabilities and Aging Committee.

f. Develop and implement a plan for a series of inservice training sessions. The plan would include at a minimum:

- description of (1) the characteristics and needs of persons with MR/DD who are aged and aging and (2) related training needs for staff who work in MR/DD and Aging programs.
- identification, review, modification of existing training packages/ materials related to MR/DD Aged and Aging.
- description of training content areas to include (1) use of generic resources (2) normalized life styles for older adults, (3) adult education strategies and (4) systemic manpower training approaches, e.g. the project coordinator needs to establish a consultative relationship with the administration of participating agencies and facilitate a consultative relationship between the staff receiving the training in the agency and the administration of the agency.

- development of competencies related to training content areas and evaluation procedures specific to those competencies.

- description of training methodologies for staff who work with older adults with MR/DD.

- modification of existing relevant training materials and development of new materials where none exists.

- compilation of training package: the training package would be reviewed by the Ohio DD Planning Council Manpower Training Task Force during the outline, rough and final draft stages.

- design for recruitment of staff to be trained. Recruitment design should ensure equal representation across the state for both rural and urban areas, MR/DD and aging agencies.

- provision of staff training for 80-100 participant staff at 5/6 sites.

- internal evaluation of project.

g. Prepare a model report which describes all components for the establishment, structure and functioning of an interagency committee which is designed to address the needs of persons with MR/DD who are aged and aging. The model report should be designed as a handbook to assist other agencies/communities in the establishment of such committees.

h. In collaboration with the Alternative Community Living Arrangements Committee of the DD Council design State Plan activities for the replication of the NE Ohio Consortium model including the research component, training component, involvement of key state agencies and the provision of technical assistance.

i. Develop preliminary discussion paper which addressed plans and/or mechanisms which will secure state and local commitment and resources for ongoing training for staff in MR/DD agencies and in aging agencies.

Outcome Indicators

a. Thoroughness and clarity of research monograph.

b. Results of evaluation of competency based inservice training session.

c. Extent to which model report can be used as a "how to" manual.

d. Degree to which replication activities are clearly articulated.

e. Degree to which plans and/or mechanisms are documented which will secure state and local commitment and resources for ongoing training.

Projected Plan Year Funding

	FFY 1984 (1st year)	FFY 1985 (2nd year)	FFY 1986 (3rd year)
DD Program Funds:	$ 67,500.	To be determined	To be determined
Non-Federal Funds:	$ 22,500.		
Total:	$ 90,000.		

Priority Service Area Alternative Community Living Arrangements:

Activities to increase the capacity of institutions and agencies to provide services in the area.

TITLE (84-26) *Accessing Generic Community Services for Persons with Developmental Disabilities Including Older Adults*

GOAL

5 To ensure that the service needs of persons with developmental disabilities and related special needs (such as severe behavior problems and aging), are recognized and provided for at both state and local levels.

Three Year Objective

5.3 By September 30, 1986, a mechanism will exist to ensure that persons with developmental disabilities including older adults, have access to appropriate services and programs conducted under the auspices of the Ohio Department of Public Welfare, Pre-Admission Screening System (PASSPORT) and other related programs of the Ohio Long Term Care Council, including the Ohio Commission on Aging.

Plan Year Objective

5.3.2 Persons with developmental disabilities who seek nursing home admission, other than ICF/MR, will have been appropriately screened and will have received community services through the implementation of the Pre-Admission Screening System (PASSPORT) .

Written information will exist which describes the extent to which services and programs funded by the Older Americans Act under the auspices of the Ohio Commission on Aging can be appropriately accessed by older adults with developmental disabilities and selected adults will have received such services.

Strategy

DD Program Funds will be made available for three years to Ohio Commission on Aging.

Responsible Agent(s)

Ohio Developmental Disabilities Planning Council
Ohio Department of Public Welfare
Ohio Long Term Care Council
Ohio Commission on Aging

Target Population(s)

Persons with developmental disabilities seeking nursing home admission, other than ICF/MR.

Older adults with developmental disabilities including individuals not being currently served by the MR/DD system.

Anticipated Activities

Note: The following activities are recommended by the Ohio Developmental Disabilities Planning Council. Alternative activities which would accomplish the plan year objective and contribute in a systematic fashion to the attainment of the three year objective would be considered.

Secure staff person with expertise in MR/DD (Qualified Mental Retardation Specialist, QMRP), gerontology, staff development and training and adult education methodologies who will provide for the following:

a. Serve as MR/DD consultant to the Assessment Teams and Case Management components of the Pre-Admission Screening System (PASSPORT) pilot projects being implemented by the Ohio Department of Public Welfare.

b. Document extent to which persons with MR/DD are referred to the PASSPORT, the results of the PASSPORT assessment and the results of the implementation of community services alternatives via the case management component of PASSPORT.

c. Attend meetings of the Ohio Commission on Aging, the Ohio Long Term Care Council and the local PASSPORT Advisory Councils.

d. Become familiar with structure and functioning of the Commission on Aging.

e. Become knowledgeable re Commission plans, programs, funding sources.

f. Prepare format and materials for presentations to specialized and generic agencies on Commission structure and functioning.

g. Gather and document information on the extent to which older adults with MR/DD participate in state level programs offered by Commission.

h. Describe and analyze barriers to participation in state level programs offered by the Commission for older persons with MR/DD.

i. Articulate action that is needed to eliminate program barriers.

j. Establish working relationships with at least one Area Agency on Aging (AAA) and appropriate specialized (MR/DD) providers who serve older adults within a PASSPORT pilot project area.

k. Access and document the needs of older adults with MR/DD within the target area.

l. Identify and document AAA services within the target area, that are appropriate to meet those needs and any barriers to service access.

m. Design and implement mechanisms to link older adults with MR/DD within the target area, with appropriate services of the AAA.

n. Provide technical assistance and follow-up to AAAs and specialized providers within the target area.

o. Participate on multi-county interagency training consortia as established under the implementation of the 1984-86 DD State Plan.

p. Provide periodic information on status of activities to the Alternative Community Living Arrangements Committee of the Ohio DD Planning Council and other responsible agents as requested.

Outcome Indicators

a. Demonstrated knowledge and skills of consultant.

b. Clarity and thoroughness of written information on PASSPORT pilot projects and on state and local programs and services, funded by the Older Americans Act, with respect to their impact on older adults with MR/DD.

c. Extent to which persons with MR/DD participate in the PASSPORT pilot project.

d. Extent to which older adults with MR/DD receive or have the potential to receive services funded by the Older Americans Act.

Projected Plan Year Funding

	FFY 1984 (one year)	FFY 1985 (2nd year)	FFY 1986 (3rd year)
DD Program Funds:	$ 35,550.	$ 34,850.	To be determined
Non-Federal Funds:	$ 11,850.	$ 11,587.	
Total:	$ 47,400.	$ 46,437.	

Priority Service Area Alternative Community Living Arrangements:

Activities to increase the capacity of institutions and agencies to provide services in the area.

TITLE (84-27) *Manpower Training Task Force*

GOAL

6 To improve the quality of service provided to persons with developmental disabilities living in Ohio by identifying and providing for the ongoing educational needs, including skills/knowledge in systemic training and systemic training approaches, of professionals and paraprofessionals who work with those individuals.

Three Year Objective

6.1 A system for state and local interagency coordination of systemic and maintenance level manpower training programs will have been designed and implemented.

Plan Year Objective

6.1.1 The Ohio Developmental Disabilities Planning Council (ODDPC), Committees and major state agencies represented on Council will consistently address DD related manpower training needs.

Strategy

Council will support a state level task force of manpower specialists representing a broad spectrum of manpower training needs. The task force will convene regularly scheduled meetings and design and implement objectives and procedures in order to address manpower training issues.

Responsible Agent(s)

Manpower Training Task Force
Ohio Developmental Disabilities Planning Council

Target Population(s)

Administrators, professionals and para professionals serving, or having the potential to serve individuals with Developmental Disabilities in Ohio.

Anticipated Activities

a. Serve in an advisory role to Council and Committees on issues and objectives related to manpower training and development.

b. Serve in an advisory role to the Ohio Department of Mental Retardation/ Developmental Disabilities (ODMR/DD) Advisory Council on manpower training and development issues.

c. Serve in an advisory role to the local multi-county training consortia as established under the implementation of the 1984-86 DD State Plan.

d. Serve in an advisory capacity for the design and implementation of local multi-county training consortia and seminars related to systemic manpower training.

e. Facilitate the interface among major state agencies represented on the Ohio Developmental Disabilities Planning Council specific to manpower training issues, needs and programs.

Outcome Indicators

a. The extent to which recommendations of the ODDPC Manpower Training Task Force have been addressed and are documented.

b. Written listing of activities and accomplishments of the task force.

c. Extent to which knowledge of training activities has increased.

d. Degree to which training, training products and materials are improved in quality.

e. Degree to which duplication of training has been avoided.

f. Degree to which duplication of interagency Manpower training groups has been avoided.

Projected Plan Year Funding

None

Priority Service Area Alternative Community Living Arrangements and Child Development:

Coordinating the provision of services in the area with the provision of other services.

TITLE (84-28) *Systemic and Interagency Manpower Training Resource*

GOAL

6 To improve the quality of service provided to persons with developmental disabilities living in Ohio by identifying and providing for the ongoing educational needs, including skills/knowledge in systemic training and systemic training approaches, of professionals and paraprofessionals who work with those individuals.

Three Year Objective

6.1 A system for state and local interagency coordination of systemic and maintenance level manpower training programs will have been designed and implemented.

Plan Year Objective

6.1.2 A resource will be established to (1) develop and disseminate systemic training (training which is done well, is being done in an efficient and organized manner and contributes to an organization reaching its goals) resources and concepts, (2) to assist in state level interagency manpower training endeavors of the Manpower Training Task Force and (3) to provide consultation in the establishment of multi-county, interagency training consortia.

Strategy

DD Program funds will be made available for three years through the contract mechanism.

Responsible Agent(s)

Ohio Developmental Disabilities Planning Council
Manpower Training Task Force

Target Population(s)

Ohio Developmental Disabilities Planning Council, Manpower Training Task Force, local training consortia, administrators, professionals and paraprofessionals serving or having the potential to serve individuals with developmental disabilities.

Anticipated Activities

a. Secure resource with expertise in staff development/training and adult education methodologies.

b. In consultation with key members of the Manpower Training Task Force, Ohio DD Planning Council, (ODDPC) compile and disseminate Executive Summary and resource manual regarding systemic manpower training, including functional indicators of implementation.

c. Participate in professional conferences to disseminate information regarding systemic manpower training.

d. Provide systemic manpower training for members of the ODDPC, Manpower Training Task Force and staff of the 4, multi-county, interagency training consortia.

e. Plan and implement training specific to the needs of the ODDPC Manpower Training Task Force membership.

f. Operate library of indexed DD Training materials and additional training resources as identified.

g. The resource will be accountable to the ODDPC, Manpower Training Task Force and assist in implementation of activities as related to objectives of the ODDPC, Manpower Training Task Force.

h. Establish linkage and provide consultation for the establishment of the 4, multi-county, interagency training consortia as established under the implementation of the 1984-86 DD State Plan.

Evaluation Criteria

a. Extent to which systemic manpower training resources including resource manual, executive summary and instructional package have been prepared and disseminated.

b. Extent to which training in systemic manpower concepts has occurred, and has resulted in an increased number of individuals who are knowledgeable in the concept of systemic manpower training.

c. The identification of functional/indicators of systemic manpower training implementation.

d. Extent to which resource library is functional.

e. The degree to which linkage and consultation with 4 multi-county, interagency training consortia have occurred.

Projected Plan Year Funding

	FFY 1984 (one year)	FFY 1985 (2nd year)	FFY 1986 (3rd year)
DD Program Funds:	$ 36,000.	$ 36,000.	To be determined
Non-Federal Funds:	$ 12,000.	$ 12,000.	
Total:	$ 48,000.	$ 48,000.	

Priority Service Area Alternative Community Living Arrangements and Child Development:

Activities to increase the capacity of institutions and agencies to provide services in the area.

TITLE (84-29) *Multi-County, Interagency Training Consortia*

GOAL

6 To improve the quality of service provided to persons with developmental disabilities living in Ohio by identifying and providing for the ongoing educational needs, including skills/knowledge in systemic training approaches, of professionals and paraprofessionals who work with those individuals.

Three Year Objective

6.1 A system for state and local interagency coordination of systemic and maintenance level manpower training programs will have been designed and implemented.

Plan Year Objective

6.1.3 Multi-county, interagency training consortia will have been established or expanded in up to 4 different geographic areas of Ohio.

Strategy

DD Program funds will be made available for three years through the competitive grant process.

Responsible Agent(s)

Public or private, non profit organizations with: experience in MR/DD and adult education methodologies; a documented commitment to training endeavors; and a letter of agreement for co-sponsorship with area Special Education Regional Resource Center (SERRC).

Target Population(s)

Administrators, professionals and paraprofessionals serving or having the potential to serve the DD population in Ohio, as well as parents of individuals with developmental disabilities.

Anticipated Activities

a. Establish or expand multi-county interagency training consortium including local representation of state agencies as represented on the Ohio Developmental Disabilities Planning Council (ODDPC) Manpower Training Task Force; SERRC; and other major organizations concerned with DD training.

b. Secure formal commitment from participants.

c. Compile and distribute information on individual agency training policies, procedures, activities, resources, etc.

d Compile and disseminate a training calender

e. Identify priority populations to be trained and content areas.

f. Design and implement training which reflects priority needs including (1) identification and referral of individuals with developmental disabilities and (2) appropriate developmental disabilities related training for staff in mental health hospital settings.

g. Design and implement mini grant/contract program to facilitate joint training by consortium membership.

h. Coordinate activities with regional (ODDPC) Public Images Consortium groups.

i. Establish project staff linkage with the Ohio Developmental Disabilities Planning Council Manpower Training Task Force via participation in monthly Task Force meetings.

j. The ODDPC Manpower Training Task Force will serve as an advisory body to the multi-county training consortia.

k. Collaborate with systemic manpower training project staff as established under the implementation of the 1984-86 DD State Plan re the establishment and functioning of interagency training consortia.

l. Project staff to become knowledgeable in the 3 levels of systemic manpower training concept as such training is provided to the ODDPC Manpower Training Task Force.

Outcome Indicators

a. Extent to which up to 4 multi-county interagency training consortia are established or expanded and functioning.

b. Extent of linkage and coordination between consortia, ODDPC Manpower Training Task Force, and systemic manpower training project.

c. Extent to which training is provided in a coordinated fashion.

d. Extent to which training calenders are compiled and disseminated.

e. Extent to which project staff have basic knowledge in the 3 levels of systemic manpower training.

Projected Plan Year Funding

	FFY 1984 (one year)	FFY 1985 (2nd year)	FFY 1986 (3rd year)
DD Program Funds:	$ 90,800.	$ 207,000.	To be determined
Non-Federal Funds:	$ 30,267.	$ 69,000.	
Total:	$121,067.	$ 276,000.	

Priority Service Area Alternative Community Living Arrangements and Child Development:

Coordinating the provision of services in the area with the provision of other services.

TITLE (84-30) *Informing the Developmental Disabilities Community about Legislative Activity*

Goal

7 To strengthen the voice of persons with developmental disabilities in Ohio through support of advocacy efforts.

Three Year Objective

7.1 Collaborative efforts by state-level agencies and organizations concerned with services to persons with developmental disabilities to (a) analyze legislative and budgetary needs for developmental disabilities, and (b) disseminate information on legislative, budgetary and advocacy activities will be organized and implemented.*

Plan Year Objective

7.1.1 Information sharing between individuals, organizations, and agencies concerned with services for persons with developmental disabilities will be coordinated and technical assistance and training for the purpose of systems advocacy will be provided.

Strategy

Based on successful completion of the 1983 plan year activity for Systems Advocacy, funds will be allocated to the Ohio Coalition for the Education of Handicapped Children for the purpose of facilitating the provision of pertinent information to the MR/DD Coalition and its constituents.

Responsible Agent(s)

Ohio Coalition for the Education of Handicapped Children (OCEHC)
MR/DD Legislative Coalition

Target Population(s)

Individuals, organizations, and agencies concerned with services for persons with developmental disabilities.

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*These funds may not be used for lobbying.

Anticipated Activities

a. Assist in moving forward the legislative priorities of the MR/DD Legislative Coalition and its constituents; coordinate the dissemination of legislative, budgetary, and advocacy information.

b. Provide staff support to the MR/DD Legislative Coalition; attend legislative hearings; attend and/or give presentations at legislative meetings of other developmental disabilities organizations across the state; provide presentations to the MR/DD Legislative Coalition and the DD Council; organize informational meetings on legislative, budgetary and advocacy matters across the state for consumers and professionals.

c. Analyze specific federal and state legislation relevant to persons with developmental disabilities and prepare written reports.

d. Mail approximately two (2) mailings a month to a mailing list of 3,000; staff will be responsible for ensuring that the mailing is done and in a timely manner.

e. Assist with the telephoning of information to the MR/DD Legislative Coalition and its constituents; communicate by telephone information that cannot be mailed in a timely manner.

f. Keep the MR/DD Legislative Coalition mailing list correct and current; the project site will work with a word processing firm to ensure that all corrections and additions are made to the mailing list.

g. Disseminate the previously prepared information package on the state legislature and the state legislative process; update the information package as necessary.

h. Disseminate the previously prepared information package on the MR/DD Legislative Coalition's legislative, budgetary and advocacy priorities and activities; update the information package as necessary.

i. Prepare and disseminate a newsletter.

j. Serve as a vehicle for implementing systems advocacy activities in the State Plan for Developmental Disabilities.

k. In cooperation with a special sub-committee of the Child Development Committee, take appropriate action to promote and enhance the acquisition of permanent state funding for services provided by University Affiliated Facilities (UAFs) and University Affiliated Programs (UAPs) since they provide prevention, early identification, comprehensive interdisciplinary assessment, interdisciplinary professional training and early intervention services that are funded primarily through non-state funding patterns. Develop strategies for accessing funding, identify and work with a lead agency to sponsor a line item or other appropriate mechanism in the state budget, and actively strive to ensure a stable funding source.

Outcome Indicators

a. Quality and timeliness of information disseminated.

b. Extent to which information reaches grass roots.

c. Degree of increased participation of consumers and advocacy groups in the legislative process.

d. Degree to which legislative priorities of the Developmental Disabilities Planning Council and the MR/DD Legislative Coalition are moved forward.

e. Extent to which permanent state funding for UAFs and UAPs is investigated, actively pursued and secured.

Projected Plan Year Funding

	FFY 1984 (one year)
DD Program Funds:	$ 168,000.
Non-Federal Funds:	$ 56,000.
Total:	$ 224,000.

Priority Service Area Alternative Community Living Arrangements and Child Development

Activities to increase the capacity of institutions and agencies to provide services in the area.

TITLE (84-31) *Coordinated Public Awareness Campaigns*

GOAL

8 To expand and improve services for persons with developmental disabilities by increasing public acceptance of persons with developmental disabilities and by increasing public awareness of the nature of developmental disabilities.

Three Year Objective

8.1 By September 30, 1986, annual plans for public awareness, with strategies for multi-year continuation, will be implemented.

Plan Year Objective

8.1.1 Implementation of the plan for coordinating public awareness efforts across groups at state and county levels will continue and public awareness efforts will be coordinated by developing linkages among county and state agencies which serve persons with developmental disabilities.

Strategy

Funds will be made available through an allocation to the appropriate entity.

Responsible Agent(s)

Professional Association for Retardation
County Boards of Mental Retardation/Developmental Disabilities
Ohio Public Images Advisory Board
Public Awareness Campaign Board

Target Population(s)

County Boards of Mental Retardation/Developmental Disabilities, members of the Ohio Public Images Consortium, Department of Mental Retardation/Developmental Disabilities, and other agencies/organizations concerned with services to persons with developmental disabilities.

Specific audiences will be targeted for some public awareness activities, i.e., legislators, new parents, potential employers.

The general public will be targeted for messages about public acceptance/awareness.

Anticipated Activities

a. Project Coordinator will design an annual plan of public awareness activities which focus on the needs determined in the 1982-83 plan year: public acceptance, early intervention, community employment, and legislative awareness.

b. Project Coordinator will work with appropriate Committees of Council and the Ohio Department of Mental Retardation/Developmental Disabilities to design annual activities.

c. Project Coordinator will provide technical assistance in public relations skills to county and state agencies through regional training sessions and in a bimonthly technical journal, "Impact".

d. Project Coordinator will identify audio visual materials for purchase and Public Awareness Campaign loan to county and state agencies to increase public awareness/acceptance of persons with developmental disabilities.

e. Project Coordinator will staff the following activities of the Ohio Public Images Consortium:

- Monthly meetings of the Advisory Board
- Committees of the Advisory Board, including Developmental Disabilities Month, Media Awards and annual conference
- Regional meetings on a quarterly basis

f. The project will serve as a vehicle for implementing public awareness activities in the State Plan for Developmental Disabilities.

g. Project Coordinator will coordinate activities with staff of the MR/DD Legislative Coalition when appropriate.

h. Project Coordinator will continue implementation of the plan for coordinating public awareness efforts across groups at state and local levels.

Outcome Indicators

a. Each public awareness or technical assistance effort should be evaluated according to:

- relationship to identified need
- quality and innovativeness of presentation or product
- dissemination of products
- degree of county level coordination achieved through regional Public Images meetings
- degree of coordination evidenced with state level groups
- effectiveness of Public Images Advisory Board activities

b. Progress made toward the development of plans for public awareness.

Projected Plan Year Funding

	FFY 1984 (one year)
DD Program Funds:	$ 87,112.
Non-Federal Funds:	$ 29,037.
Total:	$ 116,149.

Priority Service Area Alternative Community Living Arrangements and Child Development

Activities to increase the capacity of institutions and agencies to provide services in the area.

TITLE (84-32) *Improving the Provision of Appropriate Services to Persons with Developmental Disabilities other than Mental Retardation*

GOAL

9 Appropriate services will be available to all persons with Developmental Disabilities as defined by P.L. 95-602.

Three Year Objective

9.1 By September 30, 1986, a plan will have been developed which describes how state and local agencies will meet the needs of persons with developmental disabilities other than mental retardation and implementation of that plan will have begun.

Plan Year Objective

9.1.1 Needs of persons with developmental disabilities other than mental retardation will be made known to the Department of Mental Retardation/Developmental Disabilities, other state and local agencies, and the Ohio Legislature, so that planning for the provision of appropriate services and necessary resources can begin.

Strategy

DD Program funds will be made available for three years through the competitive grants process.

Responsible Agent(s)

Applicants must be public or private, non-profit organizations meeting the following criteria:

- knowledge of service needs of persons with developmental disabilities other than mental retardation
- knowledge of the service delivery system in Ohio
- ability to work closely with the Ohio DD Alliance for Service Eligibility (ODDASE), Public Awareness Campaign, and the MR/DD Legislative Coalition
- ability to assume fiscal responsibility for the project with respect to the DD Program grant

Target Population(s)

Persons with developmental disabilities other than mental retardation to include Cerebral Palsy, Epilepsy, Spina Bifida, Tourette Syndrome and Autism.

Anticipated Activities

a. State and local agencies responsible for providing services to persons with developmental disabilities will be identified.

b. The project will work with appropriate consumer groups and professional organizations to determine what services are needed by, but are not available to, persons with developmental disabilities other than mental retardation.

c. The project will work with state and local agencies to determine what services are currently being provided to persons with developmental disabilities other than mental retardation.

d. Transitional and ongoing services and supports necessary for independent living will be identified.

e. Data made available to and collected by the project will be systematically disseminated in an effective manner.

f. The project will work with the MR/DD Legislative Coalition to educate the State of Ohio Legislature about the needs of persons with developmental disabilities other than mental retardation (including necessary resources).

g. The project will work with the Public Awareness Campaign to educate the public about the needs of persons with developmental disabilities other than mental retardation.

h. The ODDASE will act in an advisory capacity to the project; members will receive reimbursement for related travel and child care expenses.

i. The project will provide technical assistance and training to the Department of Mental Retardation/Developmental Disabilities and other state and local agencies regarding the needs of persons with developmental disabilities other than mental retardation.

Outcome Indicators

a. degree to which information disseminated by the project is utilized by state and local agencies

b. degree to which the project facilitates cooperative planning for the provision of services

Projected Plan Year Funding

	FFY 1984 (1st year)	FFY 1985 (2nd year)	FFY 1986 (3rd year)
DD Program Funds:	$ 49,975.	to be determined	to be determined
Non-Federal Funds:	$ 16,658.		
Total:	$ 66,633.		

Priority Service Area Alternative Community Living Arrangements and Child Development:

Activities to increase the capacity of institutions and agencies to provide services in the area.

TITLE (84-33) *Expanding and Improving Services for Persons with Tourette Syndrome*

GOAL

9 Appropriate services will be available to all persons with developmental disabilities as defined by P.L. 95-602.

Three Year Objective

9.1 By September 30, 1986, a plan will have been developed which describes how state and local agencies will meet the needs of persons with developmental disabilities other than mental retardation and implementation of that plan will have begun.

Plan Year Objective

9.1.2 The Tourette Syndrome Association of Ohio will raise $13,200. toward a permanent support base and will provide current and updated needs assessment information to assist in the development of a plan to meet the needs of persons with developmental disabilities other than mental retardation.

Strategy

DD Program funds will be allocated for nine (9) months to the Tourette Syndrome Association of Ohio

Responsible Agent(s)

Ohio Developmental Disabilities Planning Council
Tourette Syndrome Association of Ohio
Ohio DD Alliance for Service Eligibility (ODDASE)
Public Awareness Campaign
MR/DD Legislative Coalition

Target Population(s)

Persons with Tourette Syndrome

Anticipated Activities

a. Raise funds through: a membership campaign, statewide coordinated fund raising efforts; local fund raising efforts, contact with private foundations and industries.

b. Analyze data from the statewide needs assessment and establish priority areas for service training needs.

c. Participate in activities of the ODDASE.

d. Analyze information related to past service provided by the Tourette Syndrome Association of Ohio to assess impact.

e. Provide all pertinent needs assessment and service impact information to assist in the development of a plan to meet the needs of persons with developmental disabilities other than mental retardation.

f. Provide information, referral, advocacy, public awareness and education on Tourette Syndrome through operations in the central Tourette Syndrome Association Office and regional support groups.

Outcome Indicators

a. Degree to which funds of $13,200. are raised toward a permanent support base.

b. Degree to which needs and service impact information contributes to a plan to meet the needs of persons with developmental disabilities other than mental retardation.

Projected Plan Year Funding

	FFY 1984 (9 months)
DD Program Funds	$ 56,270.
Non-Federal Funds:	$ 18,757.
Total:	$ 75,027.

Priority Service Area Alternative Community Living Arrangements and Child Development:

Activities to increase the capacity of institutions and agencies to provide services in the area.

TITLE (84-34) *Accessing Generic and Specialized Services*

GOAL

3 To enable people with Developmental Disabilities to live in the least restrictive environment, existing State and Federal Resources will be strenghtened and the development of new resources will be stimulated.

Three Year Objective

3.5 By September 30, 1986, plans consistent with the principle of normalization, will have been developed and implemented which articulate the elements and processes necessary for accessing all generic and specialized services for persons with developmental disabilities needing such services and which document services not available.

Plan Year Objective

3.5.2 A community team in both a rural and urban area will have designed and begun to implement a plan that will (1) assist generic agencies in modification/adaptation of their programs in order to effectively respond to persons with developmental disabilities and (2) ensure access to specialized services for persons with developmental disabilities.

Strategy

DD Program Funds will be made available for three years through the competitive grant process.

Responsible Agent(s)

One rural and one urban public or non-profit organization.

Target Population(s)

Persons with developmental disabilities, ages 5 years and older, including those individuals with developmental disabilities not currently served by the MR/DD system.

Anticipated Activities

Note: The following activities are recommended by the Ohio Developmental Disabilities Planning Council. Alternative activities which would accomplish the plan year objective and contribute in a systematic fashion to the attainment of the three year objective would be considered.

a. Initiate preliminary planning for the establishment of a community team of providers, consumers, advocates, key governmental persons.

- purposes of initial meeting
- identifying persons to be invited (representation must include County Board of MR/DD)
- methods for inviting participants
- who should extend invitation
- how should invitation be extended
- planning and conducting initial meeting (when, where, who hosts, agenda including potential benefits for participation)

b. Convene the community team on a regular basis in order to accomplish the following:

- a description of the community target area
- design methods for (1) identifying the community needs for specialized and generic services with a priority ranking of these needs; (2) identifying and describing all specialized and generic service resources within the target area including but not limited to counseling, material assistance, employment/vocational, financial counseling, volunteer, recreation, social, medical/health, housing, legal, transportation, nutrition, education, occupational therapy, physical therapy, dental and vision, etc.; and (3) identify services which are not available
- generate a list of goals for the team and its purpose
- specify the team mission
- specify problem areas/barriers to accessing the full range of specialized and generic services, such as, transportation, architecture, staff training, information and referral, general public awareness, funding, agency commitment, eligibility criteria, manpower, funding, policies and procedures, etc.

- design method to identify problem areas which are most likely to be resolved and to have a greater impact
- translate specific problem areas in goal statements, objectives and strategies to achieve objectives - goal statements should reflect the mission statement of the community team and the DD State Plan objective
- document processes and procedures for development of model report
- initiate implementation of strategies to achieve objectives

c. Establish linkage and coordination with other local interagency collaboration efforts (Magrab and Comprehensive Family Support Projects) if located in the area.

Outcome Indicators

a. Extent of documentation of the structure and functioning of a community team.

b. The quality and comprehensiveness of goals, objectives and strategies designed as part of the generic and specialized services plan.

Projected Plan Year Funding

	FFY 1984 (one year)	FFY 1985 (2nd year)	FFY 1986 (3rd year)
DD Program Funds:	$ 60,000.	To be determined	To be determined
Non-Federal Funds:	$ 20,000.		
Total:	$ 80,000.		

Priority Service Area Alternative Community Living Arrangements:

Coordinating the provision of services in the area with the provision of other services.

TITLE (84-35) *Training Parents of Adolescents with Developmental Disabilities*

GOAL

1 To lower the incidence of developmental disabilities through better utilization of existing services and knowledge

Three Year Objective

1.10 By September 30, 1986, training will have been provided to parents of adolescents with developmental disabilities to enable the parents to provide family life education to their children.

Plan Year Objective

1.10.1 By September 30, 1984, there will have been developed and implemented a project which demonstrates, in urban and rural areas, effective strategies and techniques for teaching parents how to provide family life education to their adolescent children with developmental disabilities.

During the second and third plan years, training will continue and, in addition, the curriculum and information on the training methodologies will be disseminated to other agencies which serve adolescents who are developmentally disabled.

Strategy

Funds will be made available through the competitive bidding process for a period not to exceed three years for one project which will review existing curricula and begin implementing a training program for parents interested in providing family life education in the home to their children.

Responsible Agent(s)

Agencies which serve adolescents who are developmentally disabled and possess expertise in adult education strategies and methodologies needed for teaching parents.

Target Population(s)

Adolescents who are developmentally disabled and their parents.

Anticipated Activities

a. Examine existing family life education curricula and modify as appropriate for training parents of adolescents with developmental disabilities.

b. Establish an advisory board which includes at least two parents of adolescents with developmental disabilities and a member of the DD Council's Manpower Training Task Force and a member of the Child Development Committee.

c. Utilize trainers who have experience in conducting education or training programs for adults.

d. Explore possibilities for provision of continuing education credits to those parents who would be interested.

e. Package and disseminate the curriculum and information on training methodologies.

f. Develop an action plan, including specific timelines and activities, to ensure that the training efforts continue and become a permanent part of the service delivery system in Ohio.

Outcome Indicators

a. Extent to which existing curricula is used.

b. Degree of involvement of parents in the planning process.

c. Degree of trainers' expertise and experience in adult education methods.

d. Number of parents who participate in the training.

e. Feedback from parents on the value and usefulness of the training.

f. Difference in participants' pre and post-test results.

g. Extent to which agencies incorporate the training.

h. Number of agencies to whom curricula and other materials are disseminated.

Projected Plan Year Funding

	FFY 1984 (1st year)	FFY 1985 (2nd year)	FFY 1986 (3rd year)
Federal Funds:	$ 60,000.	$ 65,000.	$ 65,000.
Non-Federal Funds:	$ 20,000.	$ 26,667.	$ 26,667.
Total:	$ 80,000.	$ 86,667.	$ 86,667.

Priority Service Area Child Development:

Activities to increase the capacity of institutions to provide services in the area.

TITLE (84-36) *Training in Inter-Disciplinary Approaches to Diagnosis and Assessment*

GOAL

2 To ameliorate the effects of developmental disabilities by ensuring that all children in Ohio have access to early identification and appropriate intervention services as needed.

Three Year Objective

2.7 By September 30, 1986, community personnel involved in diagnosis, assessment and individualized program development for children under 5 with developmental delays or disabilities will have had access to training in inter-disciplinary approaches to diagnosis and assessment.

Plan Year Objective

2.7.1 By September 30, 1984, existing curricula and training methodologies will have been reviewed, the curriculum for this training will have been compiled, and the appropriate training programs to upgrade the skills of practicing professionals in inter-disciplinary diagnosis and assessment will have begun.

Strategy

Funds will be allocated to the Ohio Consortium for Developmental Disorders for development and implementation of the training program, which is to emphasize on-site training, and to provide the participants with an understanding of:

1) The roles of disciplines including their own;
2) The rationale for and the organization of an inter-disciplinary team;
3) The role of group process and the principles of group leadership and group membership which influence inter- disciplinary functioning
4) Current inter-disciplinary issues of significance in the field of developmental disabilities;
5) The key legislation.

Piloting of more than one training model is encouraged. The Consortium will formulate and describe specific plans for continuation of this activity within their systems.

Responsible Agent(s)

Ohio Consortium for Developmental Disorders

Target Population(s)

Personnel of community agencies who are involved in diagnosing, assessing and developing individualized programs for children under 5 with developmental disabilities.

Anticipated Activities

a. Establish an advisory board with representatives from at least 5 distinct geographic areas of the State, composed of all groups to be trained and including a member of the Task Force or the Child Development Committee, to oversee the development of and hold final approval over products and training methodology.

b. Design the training so that support continues until the trainers determine that trainees have developed competencies in the inter-disciplinary approach to diagnosis and assessment.

c. Identify experts in inter-disciplinary diagnosis and assessment from all areas of the State, who will be available on a permanent basis to provide resources and consultation to community agency personnel upon request.

d. Ensure that the curriculum includes content pertaining to the parent's role in interdisciplinary assessments.

e. Develop specific action plans to insure that the training becomes incorporated within the agencies involved, including: establishing staff assignments and timelines for this task, developing materials which will enable the agencies to continue the training and obtaining administrative commitments to continue the training.

f. Coordinate the training logistics via the Manpower Training Task Force of the DD Council, which is designing a calendar of training sessions in Ohio.

g. Insure that the training is available and accessible to professionals in geographic areas of the state and that professionals throughout the state are made aware of the availability of the training.

h. Make periodic progress reports to the Task Force and the Child Development Committee.

Outcome Indicators

a. Number of participants trained.

b. Results of pre and post testing of trainees.

c. Feed back from trainees regarding usefulness of the training.

d. Extent to which the training becomes self sustaining in agencies involved.

e. Extent to which the curriculum materials are incorporated into ongoing training on a state-wide basis.

Projected Plan Year Funding

	FFY 1984 (1st year)	FFY 1985 (2nd year)	FFY 1986 (3rd year)
Federal Funds:	$ 80,000.	$ 100,000.	$ 100,000.
Non-Federal Funds:	$ 26,666.	$ 33,333.	$ 33,000.
Total:	$ 106,666.	$ 133,333.	$ 133,333.

Priority Service Area Child Development:

Training of personnel to provide services in the area.

TABLE 5-2
SUMMARY OF PROPOSED DEVELOPMENTAL DISABILITIES EXPENDITURES

STATE Ohio

FY ENDING 84

FEDERAL DD FISCAL YEAR ALLOTMENT $ 1,950,448.

A. Allocations to State Agencies by Source of Funds (Projected)

Designated State Agencies 1	Non-Federal Funds State 2	Local 3	Non-Profit 4	Total (2+3+4) 5	Federal* Funds 6	Total (5+6) 7
DMR/DD	$ 472,053.	$ 178,096.		$650,149.	$1,950,448.	$2,600,597.
Total	$ 472,053.	$ 178,096.		$650,149.	$1,950,448.	$2,600,597.

B. ALLOCATIONS TO STATE AGENCIES BY PURPOSE (PROJECTED)

Designated State Agencies 1		Total Federal & non-federal 2	Planning Council 3	Planning Other 4	Administration 5	Case Mgt. 6	Priority Service Areas Child Development 7	Priority Service Areas Altern. Com. Living 8
DMR/DD	F	$1,950,448.	$ 312,819.		$ 50,000.		$ 747,398.	$ 840,231.
	NF	$ 650,149.	70,939.		50,000.		249,133.	280,077.
Total		$2,600,597.	$ 383,758.		$ 100,000.		$ 996,531.	$1,120,308.

*Basic Formula Grant Funds under P.L. 95-602

**Contingency plans presented in Section 5 are not included in figures on this chart

5.3 APPLICATION PROCEDURE FOR SUB-GRANTEES

The process established for the sub-grant cycle and application process was developed by the DD Program Unit. The intent is to have a systematic, structured process that is complete and complies with Department policies and procedures, and to provide a competitive process that is as fair and objective as humanly possible. The process begins by publicly announcing funds available for competition by placing a legal notice in major newspapers and mailing an announcement to all agencies serving individuals with developmental disabilities. This announcement summarizes funds available, and notifies the public of a meeting time and location to receive application packets. At this meeting, the prospective applicant is given an overview of Ohio's Developmental Disabilities Program, the role of a DD Council and the Administering Agency. The applicant is given detailed information on the goals and objectives to be accomplished in the State Plan and the funds available. Also explained at this meeting are the grant application process, submission date, procedures for preparing grant application, and the review and scoring process. The applicant receives a packet which includes the Notice of Funds Available (NOFA), Section 5 (Plan Year Objectives) of the DD State Plan, Application Form, and Application Guidelines.

To review the applications, a Grants Review Panel is established. The panel consists of persons with expertise in the area to be reviewed including DD Committee or Task Force members (non-Council members); the Administrator of the DD Program Unit serves as facilitator for the review process. An orientation meeting is held for Grants Review Panel members. At this meeting, the DD Council staff present the goals and objectives to be accomplished by the grant; the Administering Agency staff present the technical aspects of the grant application and the scoring process. A second meeting is held with the Grants Review Panel to come to a consensus of opinion on the applications to be funded. The proposals are scored and ranked for approval or disapproval prior to the beginning of the Federal Fiscal Year.

SECTION 6
ASSURANCES

SECTION 6: ASSURANCES

6.1 The State assures that each designated State agency will make such reports, in such form and containing such information, as the Secretary (of Health and Human Services) may from time to time reasonably require, and keep such records and afford such access thereto as the Secretary finds necessary to verify such reports. (Sec. 133(b)(1)(C))

6.2 The State assures that it will maintain such fiscal control and fund accounting procedures as may be necessary to assure the proper disbursement of and accounting for funds paid to the State under Part C of Public Law 95-602. (Sec. 133(b)(1)(D))

6.3 The State assures that it will establish a method for the periodic evaluation of the plan's effectiveness in meeting the objectives set forth in the plan. (Sec. 133(b)(2)(D))

6.4 The State assures that funds paid to the State under Section 132 will be used to make a significant contribution toward strengthening services for persons with developmental disabilities in the various political subdivisions of the State. (Sec. 133(b)(3)(A))

6.5 The State assures that part of the funds (under Part C) will be made available to public or nonprofit private entities. (Sec. 133(b)(3)(B))

6.6 The State assures that funds paid to the State under Section 132 will be used to supplement and to increase the level of funds that would otherwise be made available for the purposes for which Federal funds are provided and not to supplant such non-Federal funds. (Sec. 133(b)(3)(C))

6.7 The State Assures that there will be reasonable State financial participation in the cost of carrying-out the State Plan. (Sec. 133(b)(3)(D))

6.8 The State assures that services furnished, and the facilities in which they are furnished, under the plan for persons with developmental disabilities will be in accordance with standards prescribed by the secretary in regulations. (Sec. 133(b)(5)(A)(i))

6.9 The State assures that buildings used in connection with the delivery of services assisted under the plan will meet standards adopted pursuant to The Architectural Barriers Act of 1968. (Sec. 133(b)(5)(A)(ii))

6.10 The State assures that services assisted under the plan are provided in an individualized manner consistent with the requirements of Section 112 (relating to habilitation plans). (Sec. 113(b)(5)(B))

6.11 The State assures that the human rights of all persons with developmental disabilities who are receiving treatment, services, or habilitation under programs assisted under this title will be protected consistently with Section 111 (relating to the rights of persons with developmental disabilities). (Sec. 133(b)(5)(C))

6.12 The State assures that special financial and technical assistance shall be given to agencies or entities providing services for persons with developmental disabilities who are residents of geographical areas designated as urban or rural poverty areas. (Sec. 133(b)(4)(D))

6.13 The State assures that it has undertaken affirmative steps to assure the participation in programs under this title of individuals generally representative of the population of the State, with particular attention to the participation of members of minority groups. (Sec. 133(b)(5)(D))

6.14 The State assures that it has made, or will make, an assessment of the adequacy of the skill levels of professionals and paraprofessionals serving persons with developmental disabilities in the State and the adequacy of the State programs and plans supporting training of such professionals and paraprofessionals in maintaining the high quality of services provided to persons with developmental disabilities in the State. (Sec. 133(b)(6)(A))

6.15 The State assures that there has been provision for the maximum utilization of available community resources, including volunteers. (Sec. 133(b)(7)(A))

6.16 The State assures that the composition of the State Planning Council meets the requirements of Section 137. (Sec. 133(b)(1)(A))

SECTION 7

Operational Definition of Developmental Disabilities
ODMR/DD Planning Areas
Review of Federally Assisted State Programs
Employee Protection Plan

SECTION 7: ATTACHMENTS

1) Guidelines used for Ohio's Operational Definition of Developmental Disabilities

2) Geographic Planning Areas of the Ohio Department of MR and DD

3) Summary Review of Federally Assisted State Programs and University Affiliated Facilities by Priority Service Area

4) Ohio's Employee Protection Plan

OPERATIONAL DEFINITION OF DEVELOPMENTAL DISABILITIES

OHIO'S GUIDELINES*

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*E. Gollay, Operational Definition of Developmental Disabilities

IV. KEY SCREENING QUESTIONS CHECKLIST *

The term "developmental disability" means a severe, chronic disability of a person which:

Check:

Is there reason to believe that the person has a severe, chronic disability? YES ___ NO ___

A. *is attributable to mental or physical impairment or combination of mental and physical impairments:*

Check two:

Does the person have a measurable physical and/or mental impairment as determined by a qualified professional? YES ___ NO ___

AND

Is the person's disability, i.e., his or her limited ability to function, a result of the impairments? YES ___ NO ___

B. *is manifested before the person attains age twenty-two:*

Check two:

Did the impairment itself begin prior to age twenty-two? YES ___ NO ___

AND

Did the impairment result in severe functional limitations (or disability) prior to age twenty-two? YES ___ NO ___

C. *is likely to continue indefinitely:*

Check at least one:

Is the body system that is impaired one which is known not to regain capacity once damaged? YES ___ NO ___

OR

Is the condition causing the mental and/or physical impairment one which is known to be chronic with little expectations of remediation or cure? YES ___ NO ___

OR

Is it professional judgment that the person is likely to remain impaired for the forseeable future? YES ___ NO ___

AND

Check:

Is the disability likely to endure even if educational interventions, environmental modifications or similar efforts are made to increase the person's ability to function? YES ___ NO ___

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* E. Gollay: Operational Definition of Developmental Disabilities

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D. *results in substantial functional limitations in there or more of the following areas of major life activity: (i) self-care; (ii) receptive and expressive language; (iii) learning; (iv) mobility; (v) self-direction (vi) capacity for independent living; and (vii) economic self-sufficiency:*

Under age 5

Check:

Is the child performing below the expected at his or her age in one or more of the following:

Self-care
Receptive and Expressive Language
Learning
Mobility

YES ___ NO ___

AND

Check at least one:

Is the amount of the delay at least 25% below age norms?

YES ___ NO ___

OR

Is assistance needed that is at least 25% more than expectation for age?

YES ___ NO ___

Age 5 to 22

Check:

Is the person performing below the level expected at his or her age in two or more of the following areas:

Self-care
Receptive and Expressive Language
Learning
Mobility
Self-direction
Capacity for Independent Living
Economic Self-sufficiency

YES ___ NO ___

AND

Check at least one:

Is the amount of the delay at least 25% below age norms?

YES ___ NO ___

OR

Is assistance needed that is at least 25% more than expectation for age?

YES ___ NO ___

Ages 22 to 64

Check:

Is the person performing below the level expected for his or her age in three or more of the following areas:

- Self-care
- Receptive and Expressive Language
- Learning
- Mobility
- Self-direction
- Capacity for Independent Living
- Economic Self-sufficiency

YES ___ NO ___

AND

Check at least one:

Is the person's level of performance at least 25% below expected for the person's age? YES ___ NO ___

OR

Is assistance needed that is at least 25% more than expectation for the person's age? YES ___ NO ___

Over Age 65

Check:

Is the person performing below the level expected for his or her age in two or more of the following areas:

- Self-care
- Mobility
- Self-direction
- Capacity for Independent Living

YES ___ NO ___

AND

Check at least one:

Is the person's level of performance at least 25% below expected for the person's age? YES ___ NO ___

OR

Is assistance needed that is at least 25% more than expectation for the person's age? YES ___ NO ___

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E. *reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated:*

Check four:

Does the person need a combination of more than one type of service, care or treatment? YES ___ NO ___

AND

Does the person need a combination of service, care and treatment sequenced over a prolonged (potentially lifelong) period of time? YES ___ NO ___

AND

Does the person need services, care or treatment provided by personnel trained in a variety of disciplines? YES ___ NO ___

AND

Do the services, care, or treatment provided to the person need to be individually planned and coordinated concurrently and over time? YES ___ NO ___

ACTIVITY	DEFINITION	EXAMPLES OF SPECIFIC ACTIVITIES OF SKILLS		DESCRIPTION OF SUBSTANTIAL LIMITATIONS
Self-Care	Daily activities which enable a person to meet basic life needs for food, hygiene and appearance.	Eating:	drinking, mealtime manners, use of utensils, mastication and swallowing.	Activities in two or more of the component skill areas must be performed at an age appropriate level: • by another person and/or • with a maximum of human assistance and/or • on a continuing or regular basis and/or • with a maximum and regular supervision and/or • with such difficulty as to take an unusually protracted amount of time
		Hygiene:	toileting, washing and bathing, toothbrushing.	
		Grooming:	dressing, undressing, hair and nail care, care of clothing, overall appearance.	
Receptive and Expressive Language	Communication involving both verbal and non-verbal behavior enabling the individual both to understand others and to express ideas/information to others.	Expressive:	use of oral or sign language or other intelligible gestures or sounds, use of mechanisms (such as letter boards or typewriters) for expression, and communicatio with others, voice control.	Receptive: unable to take in or process verbal and/or non-verbal information, or doe so at an age appropriate level: • with a maximum of human assistance and/or • on a continuing or regular basis Expressive: unable to express self (verbally or non-verbally) in a manner that can be understood by others or be able to express self at an age appropriate level only: • with a maximum of human assistance on a continuing or regular basis and/or • with such difficulty that an unusually protracted time is required and/or • if able to be understood only by a small group of people
		Receptive:	understanding through listening, auditory comprehending, lip reading, comprehending other forms o communication (e.g. sign language, reading)	
Learning	General cognitive competence and ability to acquire new behaviors, perceptions and information, and to apply experiences in new situations.	Cognition:	ability to understand informatio recognition.	Cognition, retention and reasoning are impaired such that the person is unable, or is extremely limited in ability, even with specialized intervention, to acquire new knowledge or transfer knowledge and skills to ne situations. Specifically only able to perform, at substantially below age appropriate levels, pre-academic and academic tasks
		Retention:	memory, knowledge.	
		Reasoning:	ability to generalize, to conceptualize, to see relationships among pieces of information, to use abstract concepts.	
		Pre-Academic and Academic Skills:	reading, writing, quantitative activities, shape and color recognition, etc.	

EXPLANATIONS OF AREAS OF MAJOR LIFE ACTIVITY

ACTIVITY	DEFINITION	EXAMPLES OF SPECIFIC ACTIVITIES OF SKILLS	DESCRIPTION OF SUBSTANTIAL LIMITATIONS
Mobility	Motor development and ability to use fine and gross motor skills. Ability to move one's person from one place to another with or without mechanical aids.	Movement: crawling, walking, climbing, use of mobility and aids such as crutches, wheelchair, cane or walker. Gross Motor Control: balance, posture, sitting, standing, rolling. Fine Motor Control: manual dexterity, precision movements, ability to control or direct mechanical devices. Coordination: eye-hand, perceptual-motor, body-motor.	Unable to perform mobility skills or two out of four activities can only be performed at an age appropriate level: • with maximum human assistance and/or • on a regular or continuing basis and/or • with such difficulty that an unusually protracted time is required and/or • if a barrier-free environment is required
Self-Direction	Management and taking control over one's social and personal life. Ability to make decisions affecting and protecting one's own interests.	Self-Concept: self-esteem, self-confidence. Socialization: affect, emotion, social awareness, emotional stability, leisure time activities, community involvement. Initiative: responsibility, decision making. Orientation: awareness of environment, responsiveness to environment.	Unable, at an age appropriate level, to initiate and/or maintain personal relationships, to behave socially in an acceptable manner, or to exercise judgments or can only do so with: • maximum supervision on a regular basis and/or • maximum human assistance particularly in performing tasks basic to a person's ability to protect his/her own rights

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EXPLANATIONS OF AREAS OF MAJOR LIFE ACTIVITY

ACTIVITY	DEFINITION	EXAMPLES OF SPECIFIC ACTIVITIES OR SKILLS		DESCRIPTION OF SUBSTANTIAL LIMITATIONS
Capacity for Independent Living	Age appropriate ability to live without extraordinary assistance from other persons, especially to maintain normal societal roles.	Housekeeping:	cleaning, maintenance, making beds, cooking, laundry, care of clothing.	Activities in one or more of the 3 areas cannot be performed at an age appropriate level only: • performed by another person and/or • with maximum human assistance on a regular basis and/or • if continuing supervision is provided and/or • with such difficulty as to take an unusually protracted amount of time and/or • if barrier-free environment exists
		Family Support:	maintaining relationships, being a spouse, parenting.	
		Money Management:	budgeting, purchasing, keeping track of expenditures, using money.	
		Health and Safety:	selecting appropriate clothing, balanced nutrition, health and safety.	
		Leisure Time Activities:	recreation, cultural activities, religious activities, social activities, clubs.	
		Using the Community Resources:	using transportation, telephone, post office, stores, and other community resources.	
Economic Self-Sufficiency	Maintaining adequate employment and financial support. Ability to earn a "living wage," net, after payment of extraordinary expenses occasioned by the disability. Absence of dependence on family or welfare for financial support.	Pre-Vocational & Vocational Skills:	ability to perform tasks required for a job, ability to learn new skills as needed.	Activities in one or more of the four areas cannot be performed adequately such that individual is fully dependent (or for children is likely to be dependent) upon external (public and private) sources of money as a result of limited ability to find and keep adequate employment
		Work Adjustment:	promptness, work habits, adjustment to work environment.	
		Job Finding:	ability to locate appropriate work, interviewing skills, presentation of self.	
		Income:	earning capacity.	

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RELATIONSHIPS AMONG LIFE ACTIVITY LIMITATIONS

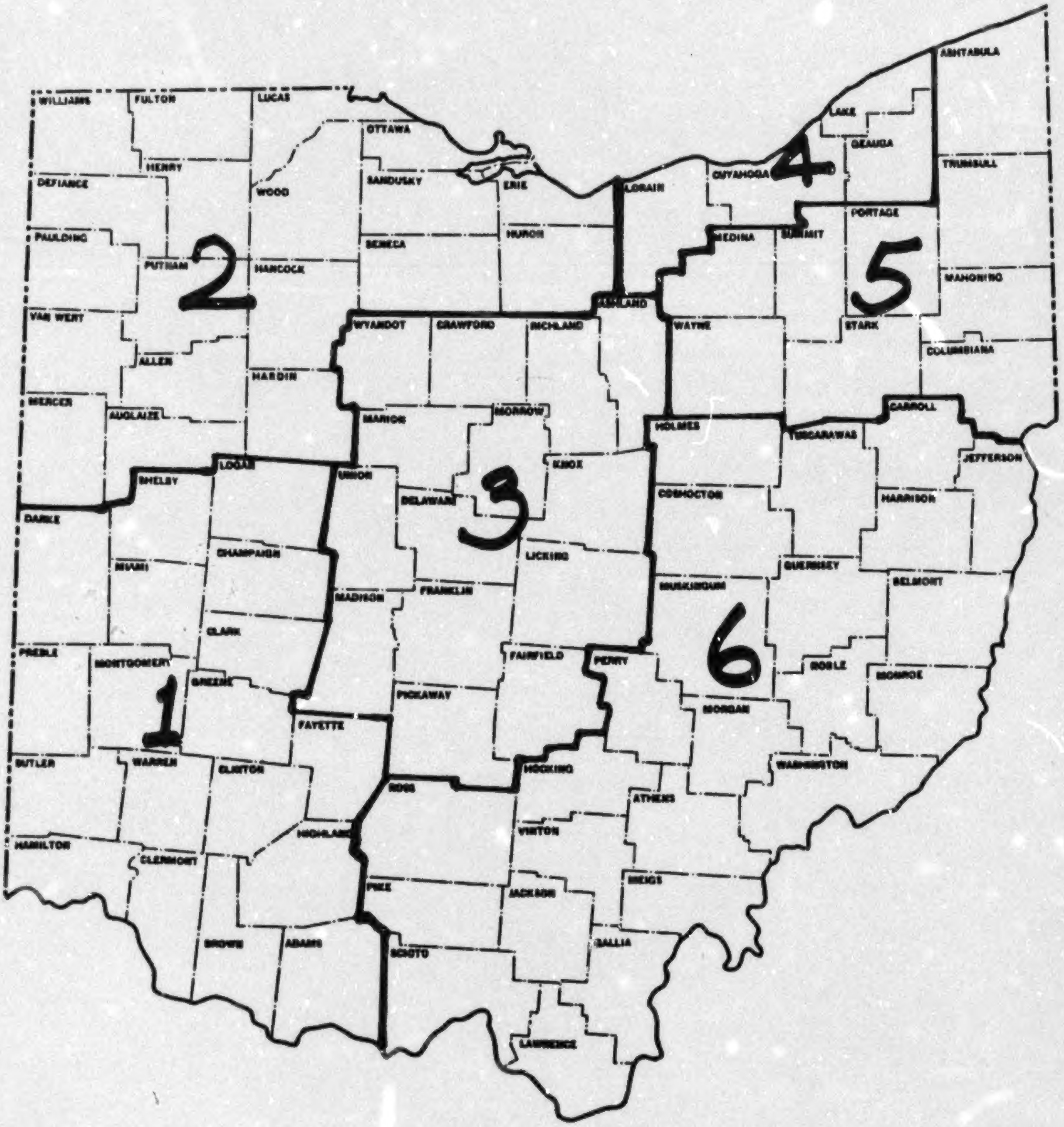
LIFE ACTIVITY LIMITATIONS		LIFE ACTIVITY LIMITATIONS: Basic Areas				LIFE ACTIVITY LIMITATIONS: Complex Areas		
		Self-care	Expressive and Receptive Language	Learning	Mobility	Self-direction	Independent Living	Economic Self-Sufficiency
Basic Areas	Self-care	—					X	X
	Expressive and Receptive Language		—	X			X	X
	Learning	X	X	–	X	X	X	X
	Mobility	X			—		X	X
Complex Areas	Self-direction					–	X	X
	Independent Living						—	X
	Economic Self-Sufficiency						X	—

X = Presence of life activity limitation

Example: If a person is limited in SELF-CARE, it is likely he/she will also be limited in INDEPENDENT LIVING and ECONOMIC SELF-SUFFICIENCY.

Planning Areas of the

Ohio Department of Mental Retardation and Developmental Disabilities


WILLIAMS
FULTON
LUCAS
OTTAWA
HENRY
WOOD
DEFIANCE
SANDUSKY
ERIE
LORAIN
CUYAHOGA
4
LAKE
GEAUGA
ASHTABULA
TRUMBULL
PAULDING
PUTNAM
2
HANCOCK
SENECA
HURON
MEDINA
SUMMIT
PORTAGE
5
MAHONING
VAN WERT
ALLEN
HARDIN
WYANDOT
CRAWFORD
RICHLAND
ASHLAND
WAYNE
STARK
COLUMBIANA
MERCER
AUGLAIZE
MARION
MORROW
HOLMES
TUSCARAWAS
CARROLL
JEFFERSON
SHELBY
LOGAN
UNION
KNOX
DELAWARE
3
COSHOCTON
HARRISON
DARKE
MIAMI
CHAMPAIGN
LICKING
GUERNSEY
BELMONT
MADISON
FRANKLIN
MUSKINGUM
CLARK
6
PREBLE
MONTGOMERY
GREENE
1
FAIRFIELD
PERRY
NOBLE
MONROE
PICKAWAY
FAYETTE
MORGAN
BUTLER
WARREN
CLINTON
HOCKING
WASHINGTON
ROSS
ATHENS
HIGHLAND
VINTON
HAMILTON
CLERMONT
MEIGS
PIKE
JACKSON
BROWN
ADAMS
SCIOTO
GALLIA
LAWRENCE

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SUMMARY REVIEW OF FEDERALLY ASSISTED STATE PROGRAMS AND UNIVERSITY AFFILIATED FACILITIES BY PRIORITY SERVICE AREA

Child Development Services Provided by Federal and State Programs

	Services												
Program	Public Awareness	Counseling	Early Identification	Diagnosis	Evaluation	Treatment	Information/ Referral	Follow-up	Early Intervention	Parent Training	Education/ Training	Income Maintenance	Transportation
Mental Retardation/Developmental Disabilities	X	X	X	X	X	X	X	X	X	X	X		X
Comprehensive Health Planning	X												
Comprehensive Mental Health Services	X	X		X	X	X		X	X				
Crippled Children's Services			X	X	X	X	X		X				
Education for the Handicapped		X	X	X	X		X		X	X	X		X
Maternal and Child Health	X			X	X	X	X				X		
Medical Assistance: Title XIX			X	X	X	X	X	X					X
Public Assistance: SSI												X	
Social Services: Title XX		X				X	X	X	X		X		X
Vocational Rehabilitation		X		X	X	X	X				X		X
Cincinnati Center for Developmental Disorders (UAF)	X	X	X	X	X	X	X	X	X	X	X		
The Nisonger Center (UAF)	X	X	X	X	X	X	X	X	X	X	X		

SUMMARY REVIEW OF FEDERALLY ASSISTED STATE PROGRAMS AND UNIVERSITY AFFILIATED FACILITIES BY PRIORITY SERVICE AREA

Alternative Community Living Arrangement Services Provided by Federal and State Programs

	Residential Services						Community Support Services										
Program	Adoption	Domiciliary Care	Foster Care	Group Living	Independent Living	Respite Care	Case Coordination	Counseling	Day Care	Employment/Training	Health Services	Income Maintenance	Legal	Protective	Recreation	Transportation	Housing Maintenance
Mental Retardation/ Developmental Disabilities		X	X	X	X	X	X	X		X	X			X	X	X	
Comprehensive Health Planning											X						
Comprehensive Mental Health Services				X		X		X	X					X			
Crippled Children's Services											X						
Education for the Handicapped											X					X	
Maternal and Child Health											X						
Medical Assistance: Title XIX		X		X							X					X	
Public Assistance: SSI												X					
Social Services: Title XX	X	X	X	X	X		X	X	X	X			X	X	X	X	
Vocational Rehabilitation								X		X	X					X	
Cincinnati Center for Developmental Disorders (UAF)						X	X										
The Nisonger Center (UAF)						X	X		X	X					X		

Ohio's Employee Protection Plan

The active depopulation of developmental centers in Ohio has meant job abolishments in some cases. In anticipation of this event, the Ohio Department of Mental Retardation and Developmental Disabilities has been implementing plans to redirect employees affected by abolishments into community based employment. Job fairs have been held at each Developmental Center which has undergone job abolishment based upon declining population. Private vendors and private providers who operate group homes, family homes and specialized care facilities under the State's Purchase of Service Program have participated in these job fairs. The purpose of the job fairs is to give employees from developmental centers whose jobs have been abolished the opportunity to find work in community facilities being developed by ODMR/DD.

Dr. Minnie Johnson, Director of ODMR/DD, has sent letters to all developmental centers which have not undergone abolishments asking that they consider for transfer those employees whose jobs have been abolished or who anticipate abolishment. Letters have also been sent to all other state agencies requesting that ODMR/DD employees be considered for hire. In addition, certain purchase of service contracts with providers of group homes, family homes and specialized care facilities stipulate that the operator must consider former employees of ODMR/DD when hiring staff.

Finally, Jim Flewellen, Chief of the Office of Human Resources for ODMR/DD is coordinating a new initiative to encourage employees or former employees of ODMR/DD to develop and operate group homes in the community. A meeting will be held soon to assist interested employees in using their knowledge, skills and commitment to get into group home development.